Missouri

UNIFORM APPLICATION
FY 2007

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 08/26/2004 - Expires 08/31/2007

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Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Missouri
DUNS Number: 780871430

Uniform Application for FY 2007 Substance Abuse Prevention and Treatment Block Grant

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

Agency Name: Missouri Department of Mental Health

Organizational Unit: Division of Alcohol and Drug Abuse

Mailing Address: 1706 E Elm Street PO Box 687

City: Jefferson City Zip: 65102-0687

II. CONTACT PERSON FOR THE GRANTEE FOR THE BLOCK GRANT

Name: Michael Couty

Agency Name: Missouri Department of Mental Health Div of Alcohol and Drug Abuse

Mailing Address: 1706 E Elm Street PO Box 687

City: Jefferson City Zip Code: 65102-0687

Telephone: (573) 751-9499 FAX: (573) 751-7814

E-MAIL: michael.couty@dmh.mo.gov

III. STATE EXPENDITURE PERIOD

From: 7/1/2004 To: 6/30/2005

IV. DATE SUBMITTED

Date: 8/29/2006 ☒ Original ☐ Revision

V. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

Name: Michael Couty Telephone: (573) 751-9499

E-MAIL: michael.couty@dmh.mo.gov FAX: (573) 751-7814

Form 2 (Table of Contents)

State:
Missouri

UNIFORM APPLICATION FOR FY 2007 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as Required by the Public Health Service (PHS) Act

The PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

We will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926:

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.
State:	Missouri
Name of Chief Executive Officer or Designee:	Dorn Schuffman
Signature of CEO or Designee:	
Title:	Director **Date Signed:**

If signed by a designee, a copy of the designation must be attached

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1)No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director
APPLICANT ORGANIZATION Department of Mental Health	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
☐ Prime ☐ Subawardee Tier _____ , if known: _____	
Congressional District, *if known:* _____	**Congressional District**, *if known:* _____
6. **Federal Department/Agency:**	7. **Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. **Federal Action Number,** if known:	9. **Award Amount,** if known: $
10. **a. Name and Address of Lobbying Entity** *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.) (last name, first name, MI):*
11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____

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DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks “subawardee”, then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES – NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director
APPLICANT ORGANIZATION Department of Mental Health	DATE SUBMITTED

Missouri

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

During FY 2004, the Missouri Division of Alcohol and Drug Abuse (ADA) supported a strong continuum of substance abuse treatment services through contracts with private treatment providers. Treatment services are made available at locations throughout the state, based on needs assessments and the availability of qualified care providers. Treatment was delivered by 44 Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs, four contracted opioid treatment programs, and 31 primary treatment programs. In total, 38,968 consumers sought substance abuse treatment from these three programs alone; a count of all those already in treatment at the start of FY 2007 would result in a much higher number.

Detoxification

Often the first step in recovery, detoxification services assist consumers in withdrawing from addictive substances in a safe, supportive, and closely monitored environment. At admission, trained staff assess a consumer's need for detoxification services utilizing physician-approved protocols. This assessment guides the individual's placement into an appropriate level of care given the consumer's physical and mental needs. The types of detoxification programs available in Missouri are medical, modified medical and social setting. During the course of detoxification, consumers are assisted in making arrangements for continuing treatment.

CSTAR

Developed by ADA and funded by Missouri's Medicaid program and ADA's purchase-of-service system, the Comprehensive Substance Treatment and Rehabilitation (CSTAR) Program provides a continuum of care approach to substance abuse treatment. CSTAR offers a flexible combination of clinical and supportive services, to include temporary living arrangements when appropriate, that vary in duration and intensity depending on the needs of the consumer. Available services include assessment, individual and group counseling, group education, community support, residential or housing support as appropriate, and family therapy. In addition, families can also participate in individual and group codependency counseling.

In FY 2004, there were three different types of CSTAR programs available in Missouri: women and children, adolescent, and general population. The women and children, adolescent, and general population CSTAR programs offer three graduated levels of care. The most intensive level offers a residential component for individuals needing that kind of structure and support. Consumers can enter the program at any level and move between levels depending on their assessed needs, problem severity and treatment progress.

CSTAR Women Treatment Programs

As substance abuse can affect women differently than men, both physically and psychologically, specialized CSTAR programs are offered for Women and Children, with programming that is relevant to women and their children. Pregnant women and women with children in their care are the priority populations. The full array of services is available and is tailored to the consumer's unique needs. In addition, daycare is provided to ensure childcare is not an obstacle to treatment. Alternative Care is a more specialized type of women and children program that resulted from a joint effort through ADA and the Missouri Department of Corrections. Designed specifically for female offenders being released from correctional institutions and those under probationary supervision, there is one program in each of Missouri's two metro areas.

CSTAR Adolescent Programs
Adolescent CSTAR programs offer to consumers 12 to 17 years of age, a full continuum of services provided by specially trained staff. Treatment focuses on issues relevant to this age group and is provided in settings that are programmatically and physically separate from adult programs. Consumers in the residential programs are offered academic support services to minimize disruptions in their education to the degree possible.

CSTAR General Population Programs
General CSTAR programs offer the complete array of substance abuse treatment and supportive services to men and women receiving Medicaid.

Opioid Treatment Programs
Opioid programs utilize physician-prescribed methadone to assist opiate-addicted consumers withdraw from these drugs while under medical supervision. Addiction treatment services are provided during and after the withdrawal protocol to help the individuals develop life skills and a recovery-focused lifestyle. Missouri's opioid treatment programs comply with applicable federal guidelines. By FY 2004, several of the ADA-contracted opioid programs had converted to the CSTAR model.

Primary Recovery and Primary Recovery Plus
At the start of FY 2004, the primary recovery programs represented the general alternative to the multi-level, Medicaid-supported, CSTAR programs. Residential and outpatient treatment were the available program options and were largely uniform in their menu of services. In an effort to provide a more comprehensive array of community-based treatment services tailored to address the unique needs of consumers, seven primary recovery residential programs participated in a pilot project, converting their former two-tiered treatment model to one patterned after the CSTAR continuum of care model described above. This conversion took place during FY 2004 and the converted programs came to be known as Primary Recovery Plus programs.

State regulations pertinent to substance abuse treatment and prevention can be found in the Code of State Regulations (CSR) 9 CSR 30-3 which was filed with the Missouri Secretary of State.

FY 2006 (Progress)

In FY 2006, the Division of Alcohol and Drug Abuse (ADA) continued to support and monitor a full continuum of substance abuse treatment services throughout the state of Missouri via contracts with private treatment providers. Treatment and support services were delivered by 41 Primary Recovery programs and 50 Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs. The number of CSTAR programs increased due to the transition of four opioid treatment programs to the CSTAR model. Two programs were converted in FY 2005 and two were converted in FY 2006.

By the start of FY 2006, all primary recovery programs had been converted to Primary Recovery Plus programs under the Access to Recovery (ATR) grant that was awarded to Missouri in FY 2005. The goals of the grant are to promote client choice in treatment and recovery support providers, expand access to a comprehensive array of treatment and support options, to include faith-based and non-traditional programs, and increase substance abuse treatment capacity. Recovery supports are intended to help keep consumers engaged in treatment for longer periods of time by addressing issues that may otherwise serve as barriers to treatment completion. By May 2006, there were 100 different providers of recovery supports. A full menu of recovery support services is available, which includes care coordination, work preparation and pastoral counseling.

The conversion of the primary treatment programs to an enhanced multi-level model resulted in key improvements to the overall system of care. First, the conversion requires that each treatment provider ADA contracts with must either provide a continuum of clinical services that are individualized to meet each consumer's assessed needs, or refer to a program that can provide this level-of-care option. Secondly, the conversion coincided with an expansion of the monitoring services provided through Clinical Utilization Review (CUR). CUR functions as a monitoring, consulting, and training unit within ADA to ensure the best consumer care is provided in an appropriate, efficient manner.

FY 2007 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to fund the established continuum of services described in the above sections, but will promote and support a wider utilization of evidenced-based practices by treatment providers.

ADA has entered a partnership with ten contracted substance abuse treatment providers throughout Missouri with a focus on the development and implementation of medication-assisted services to treat alcohol dependence, as well as, cognitive-behavioral therapy techniques used in the treatment of trauma symptoms. ADA plans to amend partner contracts to allow for the reimbursement of medication, physician, and laboratory services associated with the use of naltrexone or acamprosate. As research suggests 60-80% of consumers entering substance abuse treatment present with trauma symptoms, contracts will also be amended to allow an enhanced reimbursement rate for trauma-enhanced individual counseling and group education services.

Additionally, ADA intends to closely review the newly revised draft *Guidelines for the Accreditation of Opioid Treatment Programs* in order to evaluate the potential need for revision of our state certification standards.

Missouri

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies (See 42 U.S.C. 300x-22(b)(1) and 45 C.F.R. 96.124(b)(1)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

Information

The Missouri Division of Alcohol and Drug Abuse (ADA) supported 11 Regional Support Centers in providing information on legislative updates, team leaders meetings, grant and funding information, and conference and workshop information to over 200 community coalitions consisting of over 2000 members. ADA's Regional Alcohol and Drug Awareness Resource (RADAR) network sites located in Jefferson City, Kansas City, and St. Louis provided current prevention information to prevention practitioners at the state and community levels. ADA's RADAR network targeted people who were ages 5-64, potentially reaching 4.4 million people. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network supported local communities by providing information to the coalitions about preventing teen alcohol, tobacco, and drug use.

Merchant education materials were developed yearly and distributed to the Regional Support Centers (RSC) for dissemination during the annual tobacco merchant education campaign. A merchant training manual was developed based on the U.S. Department of Health and Human Service's "Best Practices for Responsible Retailing Conference Edition Draft". The document focused on helping retailers with the comprehensive training of sales personnel. Approximately 6,000 tobacco retailers were notified through a letter that this document was available for their use. Regional Support Centers developed a training plan based on this document and during the campaign informed retailers of the availability of technical assistance and training for their employees. Several support centers have partnered with the Division of Liquor Control and have provided training to vendors in their region.

Partners in Prevention (PIP) published a newsletter titled "Journeys". The newsletter is published quarterly and provides education and prevention messages to encourage the reduction in underage and binge drinking. A quarterly newsletter was distributed to over 200 people across the state affiliated with colleges and universities, local agencies, and community teams. A website targeting the public was created in FY 2004. Risk and Protective factors are utilized and examples of focus topics included alcohol, marijuana, underage drinking, suicide, and Fetal Alcohol Syndrome (FAS) Disorder.

Education

ADA participated in the Perinatal Substance Abuse Advisory Committee, a state-wide interagency collaboration committed to ensuring the health and welfare of pregnant and postpartum women, children and their families. The Committee identifies local and state substance abuse issues and resources, provides and promotes public and professional education, monitors compliance of RSMo 191

(Senate Bill 190), and fosters communication of stakeholders through active networking. Other state agencies involved are the Missouri Department of Health and Senior Services (DHSS), Missouri Department of Social Services, Division of Family Services, and the Missouri Department of Elementary and Secondary Education. The Committee held quarterly meetings throughout FY2004. ADA partnered with DHSS in the FAS prevention grant funded by the Centers for Disease Control and Prevention. The grant's target area was identified as approximately two-thirds of the state, excluding the metropolitan areas of Kansas City and St. Louis. Seventy-one of the 115 counties comprise this area. Data from the 2000 census and DHSS indicate that this geographic area has at least 500,000 childbearing-age women, ages 12-44. The grant was awarded in FY 2004. ADA worked closely with the DHSS to build the capacity of Missouri's communities to decrease the age of initiation of youth tobacco use and to reduce adult use. ADA was an active member of the DHSS's Comprehensive Tobacco Use Prevention Steering Committee. The purpose of the steering committee was to build a strategic plan to develop effective statewide programs to reduce tobacco use initiation, increase cessation, reduce exposure to environmental tobacco smoke and reduce disparities.

ADA's 11 RSCs conducted statewide merchant education visits between the months of February and June 2004. The purpose of these visits was to provide information and education regarding the state's law on youth access to tobacco products. Each retailer received three walk-in visits. More than 20,000 contacts were completed.

The Missouri School-based Prevention and Intervention Initiative (SPIRIT) program provided contracted training for staff from the five sites to encourage their implementation of evidence based curriculum which included Peace Builders, Positive Action for Living, and Reconnecting Youth. Three trainings were provided in Jefferson City to the SPIRIT staff members from July 2004 to November 2004.

PIP provided on-going training to 615 higher education professionals and college students through a state-wide conference and monthly meetings during FY2004.

Mobilization

The RSCs responded to the technical assistance needs of over 200 local teams, task forces and coalitions in developing the skills necessary for effective functioning. The support centers utilized a community assessment tool to survey their community coalitions in their service areas. This tool helped the teams to identify target areas, focus their work efforts, and enhance their community effectiveness. Services to diverse target populations were supported with technical assistance to enhance their capacity to support youth-based and culturally specific community groups such as deaf, Native American, and Hispanic coalitions.

PIP is a statewide coalition comprised of 12 Missouri universities across the state whose goal is to develop strategies for reducing and preventing high-risk drinking among Missouri's college students through partnerships with universities and local coalitions.

Under the direction of ADA, the Prevention Workforce Development Task Force administered a survey of the prevention field. One of the key findings was that prevention in Missouri needed to be professionalized. ADA utilized this review to identify the requirements for certified prevention professionals. The review resulted in identifying the topics for various education opportunities offered to train prevention professionals for certification. The Missouri Department of Mental Health's (DMH) annual Spring Training Institute was held May 19-21, 2004 with 981 professionals from the substance abuse prevention and treatment fields in attendance. National and local experts presented on a range of topics including co-occurring disorders, drug court, planning for successful community outcomes, and effective prevention models in the treatment setting. ADA provided training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders. The focus of the training included community assessments, capacity building, and measurable outcomes. ADA consistently collaborated with CSAP's Southwest Center for the Application of Prevention Technology to provide training and technical assistance to promote community development, accountability, and targeted prevention initiatives based on CSAP's best practice program recommendations. ADA hosted and co-sponsored the 17th annual National Prevention Network Prevention Research Conference held August 2004 in Kansas City, Missouri.

Alternatives

In addition to the support for local activities which promoted healthy alternatives to alcohol, tobacco, and other drug use, ADA supported outcomes measurement of results and the implementation of best practice prevention programs. Community coalitions provided alternative prevention activities to approximately 3000 participants throughout the year as identified by their annual community team action plans. In FY 2004, a consultant bank provided training and technical assistance in specific areas to 40 teams to develop alternative activities and program development. Another resource for communities was provided through mini-grants. Approximately 63 awards ranging from $5,000 to $10,000 were distributed under the categories of capacity building, model programs, and community norms. The average award was $6,350. ADA utilized the U.S. Education Office of Safe and Drug Free Schools Governor's Discretionary funds for the mini-grants and consultant bank resources provided to community coalitions.

Alternative prevention activities such as community service and youth leadership projects were provided to approximately 500 college aged students of the 12

Missouri universities comprising the statewide PIP coalition.

Environmental (Social Policy)

"Alcohol: Is it worth it?" was a comprehensive, broadcast media advertising campaign targeting non-urban high school-aged youth, parents, and other adults. The campaign consisted of eight diverse themed ads in a campaign which consisted of five television and three radio public service messages. One television public service announcement targeted teenage party-goers and a boys and girls campaign was aired on prime time television and radio to reach youth groups during popular shows in the genre of "Survivor," "Fear Factor," "Everwood," and the Top 40 and Hot Country radio stations. This campaign ran during the spring of 2004 and utilized 15 television stations and 115 radio stations throughout the state. Bus transit advertisements were also utilized in the urban areas of St. Louis and Kansas City. An estimated 4.5 million people were reached through the media campaign.

PIP encourages and nurtures collaboration among colleges and state agencies to develop strategies for reducing and preventing high-risk drinking among Missouri's college students and to create partnerships that will result in systemic environmental change.

Problem Identification and Referral

In June 2004, the 12 PIP universities conducted the Core Institute Alcohol and Drug Survey. The survey was administered to a random sample of 5% of the student population reaching a total of 7,048 students. The 2004 Core survey results were similar to the 2003 results, with 48% of the Missouri college students reporting engaging in binge drinking at least once within the two-week period prior to the survey and 66% stating that they used alcohol before the age of 18.

ADA provided age-appropriate, developmentally-based support services for children of women who entered treatment in the Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs, to break the cycle of inter-generation substance abuse. All contracted CSTAR treatment programs provided specialized services to women and their children to address therapeutic issues relevant to the children. Services were provided by qualified child development professionals who were knowledgeable about substance abuse prevention. Screenings were conducted for each child under age 12 whose mother was admitted for residential treatment for substance abuse. The mother's treatment record included documentation of their child's developmental, physical, emotional, social, educational, and family background and current status. When indicated with the screening, a qualified staff member completed an assessment to identify appropriate therapeutic services. There were a total of 1,500 children screened during FY 2004. The age-appropriate activities offered included training and guidance in building self-esteem; learning to identify and express feelings;

building positive family relationships; developing decision making skills; understanding chemical dependency and its effects on the family; learning to practice nonviolent ways to resolve conflict; and learning safety practices to reduce sexual abuse. These activities were provided to enhance the social and family functioning and to increase resiliency.

FY 2006 (Progress)

Information

The Missouri Division of Alcohol and Drug Abuse (ADA) information dissemination strategy was implemented through multiple prevention providers including the three Regional Alcohol and Drug Awareness Resource (RADAR) network sites, 11 Regional Support Centers (RSC), the Statewide Resource Center, the University of Missouri sites, and community coalitions. Information was disseminated using broadcast media and potentially reached 4 million individuals aged 5 to 64 years. ADA continued to support resource network involvement in health and prevention fairs, parades, resource fairs, and numerous other community team events where information on alcohol, tobacco, and other drug (ATOD) use and abuse was disseminated to community members. National prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3-D Month, and Alcohol Awareness Month also provided opportunities for RSCs and community coalitions to disseminate information about ATOD to community members. Support Center staff continued to make presentations to area civic groups at the local community levels. The community coalitions, consisting of over 2000 members, served as an ongoing venue to distribute information at the local level throughout the state. Information distributed included ADA fact sheets on alcohol, underage drinking, marijuana, women and alcohol, and methamphetamine.

Merchant education materials were developed yearly and distributed to the RSCs for dissemination during the annual tobacco merchant education campaign. The merchant education campaign consists of a phone call and two walk-in visits to the retailers. During the campaign, RSCs informed retailers of the availability of technical assistance and training for their employees. Several support centers have partnered with the Division of Liquor Control and have provided training to vendors in their region.

ADA's RADAR network sites located in Jefferson City, Kansas City, and St. Louis continued to provide current information to prevention practitioners at the state and community levels. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network continued to support local communities by providing information to the coalitions about preventing teen ATOD use and interventions for high risk groups. Several RSCs published newsletters and produced websites that provided information to their community coalitions about capacity building and important facts about ATOD. They also showcased success stories which helped motivate communities with similar circumstances and problems.

ADA continued to contract with the University of Missouri-Columbia to support the Partners in Prevention (PIP) statewide coalition comprised of 12 Missouri public institutions of higher education. The PIP is co-funded by the Missouri Division of Highway Safety and encourages and nurtures collaboration among colleges and state agencies to develop strategies for reducing and preventing

high-risk drinking among Missouri's college students and to create partnerships that will result in systemic environmental change. PIP publishes a quarterly newsletter titled "Journeys" which is sent to over 200 people affiliated with colleges and universities, local agencies, and community teams.

Education

Center for Substance Abuse Prevention (CSAP) Model Programs continued to be implemented through community-based contracts with Boys and Girls Clubs at 12 locations, faith-based sites in Kansas City, and community sites in southwest and central Missouri. The curricula and their intended audiences are: Creating Lasting Connections (children 8-12 and their parents/guardians); All Stars (children aged 11-14 years); and Smart Moves (children aged 8-17 years). The curricula were provided to over 38,000 youth.

CSAP Model Programs were also implemented through the School-based Prevention and Intervention Initiative (SPIRIT) program in five schools. The programs included Peace Builders, Reconnecting Youth, Second Step, Positive Action, and Life-Skills Training. An estimated 3,908 students were served through the SPIRIT program.

PIP continued to provide on-going training opportunities through monthly meetings and a state-wide conference. A total of 833 higher education professionals, law enforcement professionals, judicial officers, and college students participated in training activities.

Mobilization

There were approximately 200 community coalitions registered with ADA. Sustainability and capacity building continued as the focus of the 11 RSCs that provided technical assistance to the coalitions. The RSC technical assistance continued to include a community assessment that addressed strategic thinking, broad diverse community membership, coalition leadership, diversified funding sources, training, and evaluation. The RSCs continued to work with local coalitions to prioritize their goals based on the outcomes of this assessment. Local teams continued to be encouraged to work with other prevention-related teams and task forces.

The statewide coalition PIP comprised of 12 Missouri universities continued to develop strategies for reducing and preventing high-risk drinking among Missouri's college students.

Alternatives

Community coalitions and community-based providers continued to offer alternative prevention activities throughout the year. Local team action plans identified alternative activities to implement. ADA utilized the U.S. Education

Office of Safe and Drug Free Schools Governor's Discretionary funds for the technical support provided by the consultant bank. The consultant bank provided training, program development, and technical assistance to teams related to specific problem areas. Over 30 consultant bank requests were approved. Approximately 300 people were served through the requests.

Alternative prevention activities were continued through PIP. The PIP statewide coalition comprised of 12 Missouri public institutions for higher education provided community service activities and youth leadership functions as alternative prevention activities.

Environmental (Social Policy)

The RSC's provided training and technical assistance to members of community coalitions on the elements of effective coalitions. New team members received education regarding alcohol and substance abuse as part of their orientation. Information on social policy issues was provided to teams via the "ACTION" newsletter of ACT Missouri. The network of community coalitions were involved at the local district levels and at the state level by testifying before legislative committees. Community team members were involved in legislation related to zero tolerance for youth alcohol use and driving, increasing excise taxes on alcoholic beverages, opposing legalization of marijuana for medical use, and reducing methamphetamine production. Community teams also acted as change agents by educating teens about alcohol use and developing strategies for changing both laws and taxation policies related to alcohol in conjunction with Missouri's Youth/Adult Alliance.

ADA continued to participate on the Perinatal Substance Abuse Advisory Committee. This statewide interagency collaboration is committed to ensuring the health and welfare of pregnant and postpartum women, children, and their families. The Department of Mental Health's Director of Prevention was the lead writer of a grant that has enabled Missouri to develop and implement a comprehensive Fetal Alcohol Syndrome prevention effort. This project encompasses multiple risk domains and utilizes a range of preventive interventions to increase public awareness about the risks associated with any level of drinking while pregnant. These prevention efforts are expected to result in a reduction in the rate of alcohol-exposed births and will encourage proactive public policy to enhance coordination of services planned for and delivered to this population by collaborating state agencies.

PIP is a campus-based coalition comprised of representatives from 12 public universities. PIP's goal is to reduce binge drinking among Missouri's college students by three percentage points from FY 2000 baseline levels. An estimated 4,300 students were served through the Missouri PIP in FY 2006. Social-norming campaigns continued to be a coordinated priority on the college campuses.

Problem Identification and Referral

ADA continued to identify and respond to substance abuse-related problems of young children of women who were receiving treatment for substance abuse in the contracted Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs for women and their children. The focus on at-risk youth was also continued with specifically modified prevention programming provided to deaf and hearing impaired youth and adults through the operation of a “warm-line” which supports problem identification and effective referrals. Approximately 1,200 individuals have been served through the “warm-line” service.

The Core Institute Alcohol and Drug Survey (CORE) continued to be administered at the 12 publicly funded universities comprising the statewide PIP coalition. A total of 6669 students were surveyed.

FY 2007 (Intended Use)

Information

The Missouri Division of Alcohol and Drug Abuse (ADA) will continue to implement an information dissemination strategy through multiple prevention providers. This will include utilization of three Regional Alcohol and Drug Awareness Resource (RADAR) network sites, 11 Regional Support Centers (RSC), the Statewide Resource Center, the participating members of the campus based Partners in Prevention, and the collaborative community coalition partners. Statewide information dissemination will use broadcast media to potentially reach over 4 million individuals aged 5 to 64 years. ADA plans to support the resource network involvement in health and prevention fairs, parades, resource fairs, and numerous other community team events to disseminate information about alcohol, tobacco, and other drug (ATOD) use and abuse to community members. Other national prevention programs such as Red Ribbon Week, World No Tobacco Day, Kick Butts, Great American Smoke Out, 3-D Month, and Alcohol Awareness Month will also continue to provide opportunities for RSCs and community coalitions to disseminate information about ATOD to their communities. The community coalitions consisting of over 2000 members will continue to be an ongoing resource to provide information at the local level throughout the state.

Merchant education materials will continue to be distributed to the RSCs for dissemination during the annual tobacco merchant education campaign. The merchant education campaign will consist of a phone call and two walk-in visits to the retailers. During the campaign, RSCs will inform retailers of the availability of technical assistance and training for their employees.

ADA's RADAR network sites located in Jefferson City, Kansas City, and St. Louis will continue to make current prevention information available to prevention practitioners at the state and community levels. In addition to the RADAR network, the Missouri Substance Abuse Prevention Resources Network will provide support to local communities by providing information to community coalitions and teams about preventing teen ATOD use and providing effective intervention strategies for high risk groups. Regional support center newsletter publications and prevention website maintenance will also continue.

ADA will continue to contract with the University of Missouri-Columbia to support the Partners in Prevention (PIP) statewide coalition comprised of 12 Missouri public institutions of higher education. The PIP, which is collaboratively funded by the Missouri Division of Highway Safety, will continue to develop strategies for reducing and preventing high-risk drinking among Missouri's college students. PIP will continue to publish a quarterly newsletter titled "Journeys", which is currently distributed to over 200 entities affiliated with at-risk youth. In collaboration with the Missouri Department of Elementary and Secondary

Education, this newsletter and other informative materials for college-bound students may be electronically disseminated to every school system in Missouri. The prevention materials developed by PIP may be utilized by Missouri high school counselors to encourage parents of college-bound students to prepare for the ATOD issues that their children will face during their college experience. These collaborative efforts will greatly increase the current distribution and dissemination of prevention materials across the state to those who may effectively utilize them with at-risk youth.

Education

ADA will continue to implement Center for Substance Abuse Prevention (CSAP) Model Programs through community-based contracts with Boys and Girls Clubs at 14 locations in Kansas City. The curricula and their intended audiences are: Creating Lasting Connections, which is appropriate for children ages 8-12 and encourages parent and guardian participation; All Stars for children aged 11-14 years; and Smart Moves for children aged 8-17 years. An estimated 38,000 youth aged 8-17 will be served with these age-appropriate curricula.

PIP will continue to provide on-going training opportunities for higher education professionals, law enforcement professionals, judicial officers, and students on the effective prevention of alcohol and other drug abuse among Missouri college students through monthly meetings, a state-wide conference, and drive-in conferences. An estimated 850 will participate in training activities offered through the PIP program.

CSAP Model Programs will also be implemented through the School-based Prevention and Intervention Initiative (SPIRIT) program in five school districts. The programs provide Peace Builders, Reconnecting Youth, Second Steps, Positive Action, and Life-Skills Training. During FY 2007, one of the sites will expand their curricula with provision of Towards No Drug Abuse. ADA anticipates serving over 4700 youth through the SPIRIT program. In FY 2007 and FY 2008 high school programs will be added and participation will increase.

Mobilization

Ongoing support to the approximately 200 community coalitions registered with ADA will continue for FY2007. Sustainability and capacity building will continue to be the focus of the 11 RSCs providing technical assistance to the community coalitions. Community assessment will address strategic thinking, diversity in community membership, coalition leadership, developing diversified funding sources, training, and outcomes evaluation. The RSCs will also continue to work with local coalitions to prioritize their goals as indicated by their community assessment outcomes. Local teams will be encouraged to work with other prevention-related teams and community task forces including Caring Community partnerships and Community Betterment and Development teams.

This effort will be a collaborative effort with the Missouri Department of Economic Development.

ADA will continue to contract with the University of Missouri-Columbia to support the statewide PIP coalition comprised of 12 Missouri public institutions of higher education.

Alternatives

Alternative prevention activities will continue to be supported for community coalitions and community-based providers throughout the year with support from U.S. ED Office of Safe and Drug Free Community Governor's Discretionary funds. Resources to support alternative activities for approximately 4000 participants will be included in the local team action plans and will be made available through resources provided by ADA. Examples of anticipated alternative prevention activities include after school and weekend alcohol, tobacco, and other drug-free social and recreational activities, community betterment projects, and mentoring programs for at-risk youth.

The statewide PIP coalition comprised of 12 Missouri public institutions of higher education will continue to offer alternative activities to an anticipated 500 participants through community service activities and youth leadership functions.

Environmental (Social Policy)

The RSCs will provide training and technical assistance to members of community coalitions on the elements of effective coalitions. New team members will receive training regarding ATOD issues. Information concerning social policy issues will be provided to teams through the "ACTION" newsletter published by ACT Missouri. The network of community coalitions will continue their involvement at the local district levels and at the state level to support legislative initiatives which encourage prevention efforts that reduce youth risk. ADA anticipates the continued involvement of community team members in legislation related to zero tolerance for youth alcohol use and driving, increasing excise tax on alcoholic beverages, opposition to the legalization of marijuana for medical use, and measures to reduce methamphetamine production. ADA anticipates that the community teams will continue to act as change agents by educating teens about alcohol use and developing strategies for changing both laws and taxation policies related to alcohol.

ADA will continue to consistently serve on the Perinatal Substance Abuse Advisory Committee to promote a decrease in births of drug and alcohol affected babies. This state-wide interagency collaboration is committed to promoting the health and welfare of pregnant and postpartum women, children, and their families. ADA will continue to collaborate with the Department of Health and Senior Services (DHSS) to reduce the rate of alcohol-exposed births, to effect

proactive changes in public policy, and to enhance service coordination and delivery to this identified high risk target population.

ADA will continue to support PIP, the coalition comprised of representatives from 12 publicly funded universities. PIP's goal is to reduce binge drinking among Missouri college students. An estimated 4,300 students will be reached through PIP in FY2007. Social-norming campaigns will continue to be a priority for the participating college campuses.

Problem Identification and Referral

ADA will continue to identify and respond to the substance abuse related problems of young children of women who are participating in substance abuse treatment at the contracted Comprehensive Substance Abuse Treatment and Rehabilitation sites. ADA will continue to support prevention services which respond to the needs of youth and the deaf and hearing impaired populations. ADA anticipates that 1,200 individuals will be served through the "warm-line" system that provides problem identification and referral for these populations.

PIP will continue to administer the Core Institute Alcohol and Drug (CORE) survey at the 12 publicly funded universities comprising the coalition. An estimated 6,700 college students will be surveyed across the state.

State:
Missouri

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

☒ Yes ☐ No ☐ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

☐ Yes ☒ No ☐ Unknown

3. Does your State alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT BLOCK GRANT	OTHER STATE FUNDS	DRUG FREE SCHOOLS
☐ Yes	☐ Yes	☐ Yes
☒ No	☒ No	☒ No
☐ Unknown	☐ Unknown	☐ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

☐ Yes ☒ No ☐ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau? ☒ Yes ☐ No ☐ Unknown

Dissemination of materials? ☒ Yes ☐ No ☐ Unknown

Media campaigns? ☒ Yes ☐ No ☐ Unknown

Product pricing strategies? ☒ Yes ☐ No ☐ Unknown

Policy to limit access? ☒ Yes ☐ No ☐ Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxicants? (HP 26-24)

☒ Yes ☐ No ☐ Unknown

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers,

☐ Yes ☒ No ☐ Unknown

New product pricing,

☐ Yes ☒ No ☐ Unknown

New taxes on alcoholic beverages,

☐ Yes ☒ No ☐ Unknown

New Laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors,

☐ Yes ☒ No ☐ Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages.

☒ Yes ☐ No ☐ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

☒ Yes ☐ No ☐ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	☐	☐	☒	☐
Alcohol	☐	☐	☒	☐
Marijuana	☐	☐	☒	☐

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? .08

Motor vehicle drivers under age 21? .02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other durg abuse prevention (HP 26-3)? 138

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences (HP 26-11 and 26-16)?

☐ Yes ☒ No ☐ Unknown

Missouri

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

The Department of Mental Health, Division of Alcohol and Drug Abuse (ADA) has maintained the delivery of specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) services to pregnant women and mothers with dependent children. Missouri continues to offer CSTAR services to women and children suffering from the effects of substance abuse. CSTAR comprehensive programs allow women and their children to receive multiple levels of care depending on assessed need. CSTAR programs are available in each region of the state. ADA has maintained certification standards which require substance abuse treatment services for pregnant or postpartum women or women with custody of children be the first priority. During FY 2004, 400 pregnant women entered treatment upon request and received prenatal care and referrals in accordance with the requirements in the CSTAR Certification Standards and contract requirements.

Nursing services are available at the program site and a community support worker assists the client with necessary medical referrals and scheduling of appointments. Childcare is provided on-site or the program makes arrangements for child care at all CSTAR programs specializing in treatment of women and children.

Contract monitoring occurs annually through Safety and Basic Assurance Reviews at the program site. This site audit includes the area treatment coordinator reviewing the program's practices to the Block Grant Requirement Checklist to ensure compliance with Block Grant requirements. Certification surveys occur on a three year cycle and include a review to ensure pregnant women are receiving first priority for services, pregnant women are receiving prenatal care and children are receiving safe and appropriate childcare. Monitoring schedules are current, and programs are in compliance.

FY 2006 (Progress)

The Division of Alcohol and Drug Abuse continues to provide specialized Comprehensive Substance Treatment and Rehabilitation services for pregnant women and women with dependent children. During FY 2005, 540 pregnant women were admitted to substance abuse treatment services. This year additional Medicaid money is available for the treatment of pregnant women. Program staff provided orientation sessions to medical facility staff about the availability and types of treatment services available to pregnant women and their children. Evidence-based treatment to increase appropriate coping with trauma skills continues to be implemented in these programs.

FY 2007 (Intended Use)

The Division of Alcohol and Drug Abuse will continue to provide specialized Comprehensive Substance Treatment and Rehabilitation services for pregnant women and women with dependent children. The implementation of evidence-based practices will continue to be a priority as well as quality assurance monitoring of this treatment. The monitoring of programs will continue to be completed annually. An annual Safety and Basic Assurance Review that includes a review of contract, certification and block grant requirements will be completed for each agency. A certification survey of program practices and operations conducted by a team of treatment specialists will be completed every three years for each agency.

Missouri

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2004) to the fiscal year for which the State is applying for funds:

Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2004. In a narrative of up to two pages, describe these funded projects.

Attachment B (Part 1)

Treatment for women in the State of Missouri has been enhanced over the past fifteen years, due, in part, to the block grant funds. Missouri's Department of Mental Health's Division of Alcohol and Drug Abuse (ADA) has moved from providing treatment for women only in gender integrated programs to creating programs designed specifically for women and their children. Twelve contracts have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children and offer multiple treatment site locations across the state. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. All of the programs provide for licensed daycare services for the children accompanying their mothers to treatment. One program's on-site daycare has been accredited by the National Association for the Education of Young Children. The dependent children receive treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. In this manner, the mandate of Section 1922(c) in spending FY 2004 block grant funds for at least a 5% set aside has been exceeded.

Urban hospitals in St. Louis and Kansas City noted the increase in drug-affected children in the late 1980's. By 1988, the number of impaired infants brought about an organized request to ADA to begin treating pregnant and postpartum women and their children. Concurrently, the CSTAR program was being developed to meet the needs of this specific group of women and their children. Women are defined as requiring treatment when their use of alcohol and other drugs has caused dysfunction in any area of their lives. By offering a continuum of care, CSTAR is suited to match the level of care to the assessed needs of the woman and her children. This continuum of care is described below.

Continuum of Care Provided

Community-based Primary Treatment:
This is the most structured and intensive treatment in the continuum of care, and is provided in a trauma sensitive environment. Services are provided five to seven days per week. Treatment is provided in a menu of services referred to as Day Treatment, which includes up to nine hours per day of group and individual counseling, group education, and structured recovery support activities. Also available at this level of care are community support, family therapy, coping with trauma skills, residential support and day care for dependent children. Age appropriate assessment and co-dependence counseling is provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Intensive Outpatient Rehabilitation:
This treatment is designed for women who have a home environment supportive of recovery or are living in approved housing and present less severe symptoms of substance abuse. Women who have completed a more intense level of treatment are

transitioned into this level of care to provide opportunities for them to interact within their families and community while continuing to receive an intermediate level of support and treatment service. Treatment services are provided on several occasions each week. A minimum of ten hours of therapeutic activities are provided each week. Treatment is provided in a trauma sensitive environment and consists of a menu of services including; group counseling and education, individual counseling, community support, family therapy, coping with trauma skills and day care for dependent children. Age appropriate assessment and co-dependence counseling is provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Supported Recovery:
This level of care provides service on a regularly scheduled basis, usually weekly. Women who are assessed not to need intense or structured clinical services may begin substance abuse treatment at this level on the continuum of care. Women who have completed a more intense level of treatment are transitioned into this level of care to provide opportunities to interact within their families and community while continuing to receive regular reinforcement of treatment principles. The frequency of services will be determined by the assessed clinical needs of the woman. Treatment is provided in a trauma sensitive environment and consists of a menu of services including; group counseling and education, individual counseling, community support, family therapy, coping with trauma skills and day care for dependent children. Age appropriate assessment and co-dependence counseling is provided to children and family members who may have been negatively affected by the addictive behaviors of a family member.

Specialized Treatment

Women are offered group education on a wide array of topics such as drug education, communication skills, anger management, coping with trauma skills, mental health education, and relapse prevention. Group counseling is offered to allow clients to explore emotional issues and work towards healthy self image, relationships, and lifestyles. Individual counseling allows for further exploration and working towards specified individualized treatment goals.

Child care is provided at all levels of CSTAR programming for women while they attend treatment sessions. State Certification Standards require each program to be a licensed day care facility for children. A Child Therapist is required on each program staff to assess infants/children and either provide the necessary services or make appropriate referrals for infants/children with special needs. Codependency counseling and family therapy are provided for all persons identified with a need for these services.

Women who are homeless when they enter treatment may receive housing assistance from ADA while participating actively in treatment. Community housing is time limited and intended as a bridge to other, long term housing arrangements. The stipend for community housing is a maximum of $500.00 and can be used to pay rent, initial deposits, utilities and local telephone service.

All women and children who enter treatment are provided health screenings to identify health deficits or needs for medical intervention. Within the CSTAR programs, registered nurses are on duty to assist mothers and their children to achieve health goals. The nurses on-site at each facility offer medical services, referral, and education for all children and families. Each child is required to have a current physical exam and current immunizations. The Community Support Workers assist the clients in arranging medical appointments and obtaining transportation. Close associations with local health clinics, hospitals and doctors provide prenatal care, immunizations and other preventive techniques to increase the well being of mothers and their children. All CSTAR programs conduct an HIV/STD/TB risk assessment for all clients at admission. Pre and post test counseling for HIV/AIDS, STD and TB are available on site or by referral at all CSTAR women's programs. This innovative healthcare provision was a result of the FY 1997 mandate to increase and improve services for women.

Dramatic results have occurred due to the provision of treatment services specifically designed for women. In FY2006, 7186 women and children were treated in the CSTAR women and children programs. In FY2006, 134 out of 144 babies born to women in CSTAR programs were born drug free. In addition, 106 children were returned to their mother's custody from the Division of Family Services because their mothers had regained their ability to manage healthy families and live productive lives. The emotional rewards and cost savings from these program measures alone support the cost effectiveness of continuing specific substance abuse treatment for women and children. The State is moving towards a standardized outcome-based system of monitoring client improvement on numerous domains. Implementation of evidence-based practices to treat this special needs population and quality improvement are on going goals.

Missouri

Attachment B: Programs for Women (contd.)

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2004 block grant and/or State funds?

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2004 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Attachment B (Part 2)

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), type of care (refer to definitions in Section II.5), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

The capacity of Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs in all three levels are limited by the amount of general revenue and Medicaid dollars available. However, the residential component at facilities is limited to 16 beds for the primary clients and 10 beds for children. Housing can be made available for families that are homeless or alienated from their families of origin. All the women's facilities have access to supportive housing money, and therefore can offer additional safe housing options.

The number of clients served in all three levels in FY 2004 at the women's treatment programs by agency was: BASIC - 490, Bridgeway Counseling Services, Inc. - 1082, Family Counseling Center of Missouri, Inc. - 541, Family Counseling Center, Inc. - 745, Family Self-help Center - 530, Hannibal Council on Alcohol and Drug Abuse - 479 Alternative Opportunities - 583, New Beginnings Alt-Care - 469 Queen of Peace Center - 1042, Renaissance West, Inc. - 604, and Research Mental Health Services – 930, Research Mental Health Services Alt-Care - 427.
Included is a list of all women and children's CSTAR programs in Missouri including the Substate Planning Area (SPA) and the National Federal Registry (NFR) ID.

BASIC (Black Alcohol/Drug Service Information Center)
Locust, Suite 800
St. Louis, MO 63103
Allocated funds FY 2004 $597,995.00
SPA: Eastern Region
NFR ID: MO100880

Bridgeway Counseling Services
307 North Main
St. Charles, MO 63301
Allocated funds FY 2004 $948,102.00
SPA: Eastern Region
NFR ID: MO101136, MO101458

Family Counseling Center of Missouri, Inc.
McCambridge Center for Women
201 North Garth
Columbia, MO 65203
Allocated funds FY 2004 $810,057.00

SPA: Central Region
NFR ID: MO101003

Family Counseling Center, Inc.
Cape Girardeau CSTAR
20 South Sprigg, Suite #2
Cape Girardeau, MO 63701
Allocated funds FY 2004 $825,079.00
SPA: Southeastern Region
NFR ID: MO101123

Family Self-Help Center
Lafayette House Serenity Program
Box 1765, 1809 Connor Avenue
Joplin, MO 64802
Allocated funds FY 2004 $705,413.00
SPA: Southwestern Region
NFR ID: MO101029

Hannibal Council on Alcohol and Drug Abuse
146 Communications Drive
Hannibal, MO 63401
Allocated funds FY 2004 $734,090.00
SPA: Northern Region
NFR ID: MO101219

Alternative Opportunities
Carol Jones Recovery Center for Women
2411 West Catalpa Street
Springfield, MO 65807
Allocated funds FY 2004 $701,229.00
SPA: Southwestern Region
NFR ID: MO903879

New Beginnings Alt-Care
3901 N Union Blvd, Suite 101
St. Louis, MO 63115-1130
Allocated funds FY 2004 $900,658.00
SPA: Eastern Region
NFR ID: MO102092

Queen of Peace Center
325 North Newstead
St. Louis, MO 63108
Allocated funds FY 2004 $920,340.00
SPA: Eastern Region

NFR ID: MO100591

Renaissance West, Inc.
5840 Swope Parkway
Kansas City, MO 64127
Allocated funds FY 2004 $869,452.00
SPA: Western Region
NFR ID: MO100898

Research Mental Health Services North Star Recovery Services
(Two programs; Alt-Care women's Correctional and a Women and Children Program)
2801 Wyandotte
Kansas City, MO 64108
Allocated funds FY 2004 Women and Children $874,657.00
Allocated funds FY 2004 Alt-Care Women's Correctional $900,658.00
SPA: Western Region
NFR ID: MO101094

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY2004 block grant funds?

Treatment for women in the State of Missouri has continued to expand over the past fifteen years, due in part to the block grant funds. Missouri's Division of Alcohol and Drug Abuse (ADA) has moved from providing treatment for women in gender integrated programs to developing programs designed specifically for women and their children. Twelve contracts with multiple treatment site locations have implemented Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs specifically designed for women and their children in Missouri. Another program has on-site daycare accredited by the National Association for the Education of Young Children. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. The women's dependent children were provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. In this manner, the mandate of Section 1922(c) in spending FY 2004 block grant funds for at least a 5% set aside has been exceeded.

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

The specialized programs to meet the needs of pregnant women and women with dependent children are monitored on a regular basis. All CSTAR treatment programs receive a site Certification Survey every three years from a team of treatment certification specialists. The programs are reviewed for compliance with certification standards for CSTAR programs which reflect the accepted standard of care in substance treatment. In addition, Area Treatment Coordinators perform Contract Compliance and Block Grant Requirement Checklist Audits annually and make

technical assistance visits when necessary.

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

The State uses data reported by the contract providers on a routine basis for monitoring the treatment capacity and utilization by women. The Department of Mental Health maintains a central data system that identifies, among other data, the services provided, number of clients and demographics (including pregnancy at admission) of clients. Requests for treatment by women have increased substantially over the past fifteen years. In 2000, a Placement of Expanded Treatment Services document was developed to assist ADA in placement of new CSTAR – Women and Children's programs as funds became available. Through these mechanisms, areas of the state that require additional treatment resources are identified and new programs are planned.

5. What did the State do with FY 2004 block grant funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

The State of Missouri has been a leader in providing quality substance abuse treatment services to women and their children. ADA has 12 contracts providing CSTAR programs specifically for women at multiple locations. There are an increasing number of women served in state funded programs. The number of women and children treated in CSTAR Programs has increased from 2,548 in FY1995 to 7,922 in FY 2004.

Missouri

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2004) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. What did the State do to ensure compliance with 42 U.S.C. 300x-23 of the PHS Act as such sections existed after October 1, 1992, in spending FY 2004 SAPT Block Grant funds (See 45 C.F.R. 96.126(a))?

3. What did the State do to ensure compliance with 42 U.S.C. 300x-31(a)(1)(F) of the PHS Act prohibiting the distribution of sterile needles for injection of any illegal drug (See 45 C.F.R. 96.135(a)(6))?

4. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2004 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

5. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

6. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

Attachment C

1. Intravenous drug abusers include all substance abusing persons whose primary, secondary or tertiary route of administration is by needle, whether intravenously or intramuscularly.

2. During FY 2004, Missouri designated funds exclusively for intravenous drug abuse prevention and treatment services and contracted with specialized programs to provide those services. Four contracted opioid treatment programs provided services including prescription and dispensing methadone, combined with appropriate medical, recovery and detoxification services to decrease the morbidity of withdrawal from heroin or other opioid drugs. Comprehensive care programs treated intravenous drug abusers in a continuum of care including Community Based Primary Treatment, Intensive Outpatient and Supportive Recovery. The contracted specialized opioid treatment programs are located in the urban areas of Kansas City and St. Louis. However, intravenous drug abusers were admitted to and treated in other Division of Alcohol and Drug Abuse (ADA) funded substance abuse treatment programs in the state.

3. Treatment providers were prohibited by contract from distributing needles for injection of any illegal drug. The prohibition also included distribution of bleach for the purpose of cleaning for such injection. Compliance was monitored by regional staff conducting program site reviews. Monitoring did not uncover any violation or failure to comply with these requirements.

4. Throughout FFY 2004 all providers operated at or near capacity. Agencies not at capacity were quickly filled with referrals from waiting lists from other treatment programs.

   No problems have been reported with the above compliance monitoring procedure during Certification Surveys or Safety and Basic Assurance Compliance Reviews. No substance abuse treatment programs have been found operating below 90% of capacity. All substance abuse treatment programs surveyed or inspected have been operating at or above 90% of capacity.

5. Treatment providers were required to admit persons who were intravenous drug users within the past thirty days or who were in imminent danger of relapse. Provider contracts require these persons be admitted within 14 days of request. If at capacity, programs will make referrals to other resources in the community; for example, private pay opioid programs or detoxification programs. The information system designed and maintained by the Missouri Department of Mental Health has a registration option of screening/waiting rather than admission. ADA encourages each provider to maintain contact with those consumers on

their waiting list by providing interim treatment services until services at the clinically appropriate level are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those individuals seeking treatment. This has proven to be an effective process. Compliance with these regulations was monitored by regional staff during site visits using the Block Grant Compliance Checklist during Certification Surveys and Safety and Basic Assurance Reviews.

6. The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA), encourages certified substance abuse treatment providers to conduct outreach services to consumers needing treatment to address intravenous drug use. Providers are encouraged during certification surveys to engage consumer's families in treatment and to address family intravenous drug use. During the 2006 Spring Training Institute, seven training sessions provided information relevant to IV drug use treatment protocols. ADA is collaborating with treatment providers and the Missouri Department of Health and Senior Services (DHSS) to present blood borne disease prevention information to consumers and to utilize appropriate HIV and Hepatitis screening tools during consumer admission to treatment. Additionally, ADA is collaborating with treatment providers, DHSS and the Missouri Department of Corrections to educate consumers about treatment options for intravenous drug abuse.

Missouri

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2005) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below:

1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a) (See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));

2. Tuberculosis Services 42 U.S.C. 300x-24(a) (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(viii)); and

3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b) (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

- A description of the problems identified and corrective actions taken.

Attachment D

1. Notification of Reaching Capacity

All contracted substance abuse treatment agencies in Missouri's publicly funded system of care continue to remain at or near capacity. Monitoring procedures are in place to assist clients in accessing treatment as quickly as possible. Agency activity levels are monitored at the regional level through the Regional Administrators and Area Treatment Coordinators. The CTRAC information system designed and maintained by the Missouri Department of Mental Health (DMH) has a registration option of "screening/waiting" rather than admission. The Division of Alcohol and Drug Abuse (ADA) encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate level of care are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. Also, ADA assists agencies in locating treatment services throughout the state. ADA has a toll-free number advertised for consumers to call for referrals. Regional staff receive the calls and make referrals to treatment programs in the consumer's area.

The effectiveness of the above communication procedures are evidenced during regular monitoring visits. All substance abuse providers are operating at or above 90% capacity; those that are above are reported during Certification Surveys and/or Safety and Basic Assurance Reviews.

Given that providers are operating at or near maximum capacity, ADA budget requests to the legislature for FY 2004, FY 2005 and FY 2006 have all included requests for additional funds to expand the capacity limitations within the publicly funded system of care. In addition, in FY 2005 and FY 2006, ADA pursued grant funding with the same goal of increasing system of care capacity. Missouri was one of only 14 states and one tribal organization to be awarded an Access to Recovery (ATR) grant from the Department of Health and Human Services Administration in FY 2005. The Office of the Governor was awarded this $22.8 million grant, with $7.6 million allotted for each of the three grant years. Missouri's governor designated the Division of Alcohol and Drug Abuse as fund administrator.

These ATR funds were intended to assist grant recipients in designing and implementing a voucher system to pay for an expanded array of community-based clinical substance abuse treatment and recovery supports. Key elements of ADA's successful grant implementation included the following: assurance of genuine, free, and independent client choice of treatment and recovery support providers; improvement in access and an increase in capacity for substance abuse treatment and recovery support services; and, engagement of faith-based

organizations in the provision of broad-spectrum treatment services and recovery supports. The ATR program was fully implemented by April 1, 2005.

2. Tuberculosis Services

ADA collaborated with the Missouri Department of Health and Senior Services (DHSS) to access current information and training information related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain referral relationships with local health resources to facilitate tuberculosis screening and treatment for all consumers entering treatment programs. The services provided included educational information about tuberculosis, related health risks and risks of transmission. Also, tuberculosis testing services were provided to determine whether the individual has been infected with mycobacterial tuberculosis, and for those testing positive, referral for appropriate medical evaluation and treatment.

All contacted substance abuse treatment facilities are required by contract to provide for tuberculosis testing. Some facilities provide testing on site while others refer consumers to the county health department. The treatment facilities have established and maintained collaborative relationships with their county health departments. Consumers have access to testing services at any time during their treatment. Agencies may not deny access to treatment based on a positive tuberculosis test result providing the individual does not have active disease. Treatment providers are required by contract to make appropriate referrals for persons seeking services who are not admitted to their program. Treatment programs can request county health department staff observe consumers engaged in treatment take preventive medicine for a positive tuberculosis skin test.

The Area Treatment Coordinator or a treatment specialist from ADA is available to assist if an agency has difficulty finding services or has concerns about referring someone with positive tuberculosis test results. ADA staff may assess the needs of the client, advise agency staff of procedures and protocols or, if necessary, seek assistance from the DHSS, Bureau of Tuberculosis Control in determining appropriate services.

Training and education opportunities are available to provider staff through DMH and DHSS. The Division's treatment specialists, District Administrators, and Area Treatment Coordinators will continue to work with treatment providers and county health departments to maintain and improve tuberculosis services. Through site Certification Surveys, Contract Compliance Audits, and technical assistance visits, ADA will monitor tuberculosis services including; screening, referral, testing procedure, counseling, and confidentiality. Certification surveys are conducted every three years, Safety and Basic Assurance Reviews are conducted each year, and technical assistance visits as provided as needed.

The infection control recommendations and protocols for substance abuse treatment providers include but are not limited to the following procedures: screening of patients; identification of those individuals who are at high risk of becoming infected; and meeting all state reporting requirements while adhering to federal and state confidentiality requirements.

From FY 2004 to present, there have been no reports of problems with the above monitoring and compliance procedures.

3. Treatment Services for Pregnant Women

Contracts and certification standards require that all service providers specializing in women's **substance abuse** treatment must give priority to pregnant women seeking admission. Priority designations also include postpartum women or women with children in their custody. Standards require that the programs "engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria." The Division of Alcohol and Drug Abuse (ADA) has made provisions for the delivery of services to pregnant women and mothers with dependent children through the specialized women and children's Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs. These CSTAR programs allow women and their children to receive multiple levels of care depending on assessed need. Included in the service spectrum are nursing services, community support, and childcare. Specialized women's CSTAR programs are available in each region of the state.

During FY 2004, 400 pregnant women entered treatment upon request and received prenatal care and referrals in accordance with the requirements in the certification standards and contracts. During FY 2005, 540 pregnant women were admitted to substance abuse treatment services.

Contract and site monitoring occurs annually through Safety and Basic Assurance Reviews. These audits involve the Area Treatment Coordinator reviewing the program's practices to determine the level of compliance with Block Grant requirements. Certification surveys occur on a three-year cycle. These reviews assess a program's compliance with standards, which would include a review of priority admission practices, prenatal care arrangements, and childcare services. Monitoring schedules are current, and programs are in compliance.

The Division of ADA monitoring mechanisms have resulted in the discovery and rectification of some issues pertaining to the treatment of pregnant women, as well as, women with or without children in their care. During a September 2006 certification survey, a contracted women and children's substance abuse treatment provider was found out of compliance with standards due to the

provider not employing a nurse. A deficiency was cited and an action plan requested to assure provision of necessary nursing services.

Improvements to the system of substance abuse care for women also occur outside of the regulatory realm. The Division of ADA maintains reciprocal communication and collaborative relationships with treatment providers through established processes. For example, in FY 2005 two specialized women and children's programs were expending considerable resources towards individual therapy with children under the age of five years. Department psychologists, ADA clinical utilization review staff and provider clinical directors collaborated to establish clinical guidelines for the use of individual therapy with children and to encourage the use of family-based interventions. Also in FY 2005, two women and children's programs were experiencing high rates of adjustments on clinical review requests. A training and discussion session was scheduled between provider clinicians and ADA clinical utilization review staff to evaluate existing practices and discuss quality of care standards.

More recently, in FY 2006 a work group composed of women and children's providers requested a change in certification standards to allow for greater flexibility in meeting the standard related to child therapists, by employing a "career ladder" approach. A standard revision is pending. Also in this last fiscal year, a women and children's program work group requested authorization to provide residential support services to children ages 13 to 16 years who accompany their mother into treatment. Based on a lack of specific programming for older children/adolescents, as well as, concerns for the safety and appropriateness of commingling a wide range of ages, this request was denied by the division. However, the issue is still under discussion with the hopes of arriving at a suitable solution.

In each of the past three fiscal years, nearly all substance abuse providers have expressed that the difficulty in attracting and retaining qualified staff is one of the most significant challenges to their operations. The Division of ADA has attempted to address this issue through budget requests each year. The Missouri General Assembly did approve a service rate increase for providers for the current fiscal year.

Missouri

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

Treatment providers were required to admit persons who abused intravenous drugs within the past thirty days or were in imminent danger of relapse. Provider contracts require these persons be admitted within 14 days of request. The CTRAC information system, designed and maintained by the Missouri Department of Mental Health, has a registration option of screening/waiting rather than admission. The Division of Alcohol and Drug Abuse (ADA) encourages each provider to maintain contact with those consumers on their waiting list by providing interim treatment services until services at the appropriate intensity are available. Agencies within close proximity of each other have developed informal telephone communications to refer consumers to other programs when they are unable to meet the needs of those consumers seeking treatment. This has proven to be an effective process. ADA includes block grant intravenous drug abuser treatment requirements in its awarded contracts. Compliance has been consistently monitored with the Certification Survey process and annual Safety and Basic Assurance Reviews which includes the Block Grant Requirement Checklist.

FY 2006 (Progress)

The Division of Alcohol and Drug Abuse (ADA) is engaged in the implementation of the Customer Information Management, Outcomes and Reporting (CIMOR) information system which will be available for use in October, 2006. CIMOR will continue the registration option of screening/waiting pending admission. This will allow ADA to continue to identify intravenous substance abusers that are waiting for treatment options. These individuals will continue to receive contact from providers and interim treatment until they can be admitted into clinically appropriate treatment. Currently, there are 2,290 identified consumers participating in contracted treatment throughout the state that classify their primary route of drug administration as intravenous.

ADA continues to utilize certification surveys and annual Safety and Basic Assurance Reviews with the Block Grant Checklist to ensure compliance. Agencies found to be out of compliance are identified and an action plan to achieve contract and standard compliance is required. Technical Assistance, consultation, and focused compliance reviews are applied to those treatment agencies serving intravenous drug users to ensure consistent compliance and provision of high quality service to the high-risk intravenous drug abusing consumer.

Provider staff continue to participate in collaborative cross-training with the Department of Health and Senior Services. This screening and risk assessment training will increase provider staff utilization of effective targeted risk reduction intervention strategies to address the high-risk behaviors of intravenous drug users. Current screening tools and Hepatitis curriculum are prepared for distribution to all contracted treatment providers in the fall of 2006. These providers are being encouraged to utilize this material for staff training and consumer education.

FY 2007 (Intended Use)

The Customer Information Management, Outcomes and Reporting (CIMOR) information system will continue to capture the consumer screening/waiting option to monitor pending admissions for treatment. Consumers will be admitted to treatment, referred to other providers for immediate treatment or receive interim services until clinically appropriate treatment is available. Treatment agencies serving intravenous substance abusers will continue to receive consultation and technical assistance concerning the application of effective screening and intervention techniques to reduce the risk of infectious and blood borne communicable diseases which include TB, HIV/AIDS, STDs and Hepatitis. Annual Safety and Basic Assurance Reviews with the Block Grant Compliance Checklist will continue to be conducted by regional staff. This will ensure compliance with block grant requirements and quality of services provided.

The Division of Alcohol and Drug Abuse (ADA) contracted providers will be encouraged to continue their active participation in regional cross-training with the Department of Health and Senior Services. This will enhance their knowledge of effective screening and referral processes for health services and utilization of successful prevention and intervention strategies to reduce the frequency of high risk behaviors.

Missouri

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Missouri Department of Health and Senior Services to access current information, trends and training related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all clients entering treatment programs.

FY 2006 (Progress)

Contracted treatment providers have been required to make tuberculosis skin testing available to all clients in their programs. Contracted treatment providers are required to maintain effective linkages with local health departments to assist treatment program staff with client testing and monitoring efforts. Providers are monitored annually for compliance by the Safety and Basic Assurance Review survey process to ensure that TB positive clientele are identified and receive treatment services and to ensure that effective referrals are made for health services in collaboration with local health departments. The Missouri Department of Health and Senior Services (DHSS) offers assistance to contracted providers to procure TB testing supplies and they continue to provide follow-up diagnostic services for clientele who do not have health care resources. The DHSS has demonstrated their commitment to the provision of consistent TB services at the community level. Residential and opioid treatment programs are required to monitor client compliance with medications to encourage therapeutic response. The provider certification process assures that client medication compliance is addressed during the course of treatment.

FY 2007 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to make Tuberculosis risk assessment, testing, and risk reduction education available to all treatment clientele. Provision of tuberculosis specific services will continue to be monitored with annual Safety and Basic Assurance Reviews. ADA will continue to require contracted treatment providers to maintain effective linkages with their community health departments to ensure that treatment clientele access and participate in tuberculosis services. Contracted providers may continue to expect ADA support to receive technical assistance and direct intervention at the community level to access TB services. ADA will continue to offer technical assistance to encourage a successful partnership between ADA contracted providers and Department of Health and Senior Services community health departments.

Missouri

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2007 (Intended Use)

Continued efforts will be made to decrease perinatal HIV transmission. The Division of Alcohol and Drug Abuse (ADA) will continue to require all Comprehensive Substance Treatment and Rehabilitation programs for women and children to coordinate the prenatal care of all female clients. This practice will ensure that female clientele have access to prenatal care to encourage the client to address the issue of HIV testing with their physician and the treating medical facility.

ADA and the Department of Health and Senior Services (DHSS) will continue to collaborate to strengthen regional provider service networks to continue to promote knowledge exchange between ADA and the DHSS providers to address the need for effective risk reduction strategies with ADA's high-risk clientele. ADA contracted substance abuse, and prevention providers will be encouraged to maintain effective working partnerships with community health and community prevention service providers to meet the needs of their at-risk clientele.

The DHSS will continue to make HIV testing education available to ADA contracted providers who wish to provide on-site HIV testing. ADA will make technical assistance available to all contracted providers who wish to provide on-site HIV testing services.

The DHSS has encouraged ADA to address the co-infection rate of HIV and Hepatitis C among the IV Drug use population. ADA will continue to require assessment for hepatitis risk with the initial assessment process. ADA contracted providers will continue to be encouraged to include Hepatitis educational curriculum with their HIV client education as a risk reduction strategy.

The DHSS has initiated a state wide Hepatitis Plan of Action to address prevention and care of Hepatitis. ADA will continue to serve as an active participant in this collaborative process to address Hepatitis prevention, and treatment intervention needs of the substance abuse population.

ADA will continue to encourage the Partners In Prevention, a university and college campus-based prevention program, to maintain regional collaborative partnerships with the Statewide Community Planning HIV Prevention Group to encourage their utilization of effective HIV risk reduction strategies with their college population.

ADA will collaborate with DHSS and one of ADA's funded opioid programs, Rodgers South, as this program begins to provide rapid HIV testing. Rodgers South received an outside grant for rapid testing which will be implemented in 2007. ADA will not be using any block grant funding in this pilot project.

Goal #6: HIV Services Footnotes
Missouri is not a designated state.

Missouri

Attachment E: TB and Early Intervention Svcs

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))

For the fiscal year three years prior (FY 2004) to the fiscal year for which the State is applying for funds:

Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);
- the role of the single State authority (SSA) for substance abuse prevention and treatment; and
- the role of the single State authority for public health and communicable diseases.

Examples of activities include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;
- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;
- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and
- technical assistance.

Attachment E

Beginning in 1989 the Division of Alcohol and Drug Abuse (ADA) has provided TB and HIV services in the four publicly-funded methadone programs, and other selected treatment programs. Linkages between early intervention services for HIV and the IVDU Outreach Programs included methadone service providers as well as other identified efforts, particularly in St. Louis and Kansas City.

Since July 1, 1993 all substance abuse treatment programs have provided TB and HIV services to clients entering treatment by arranging with a nearby health clinic to provide clients with TB testing and counseling. Testing and other services are provided by the local health clinic with a referral from the substance abuse treatment program. All clients, whether admitted or not, are offered the service. Follow-up counseling and ongoing services are then provided collaboratively between the substance abuse provider and the health clinic. An ADA Treatment Specialist coordinates the HIV and TB services with the Department of Health and Senior Services (DHSS), local county health departments, and substance abuse programs to ensure services are available to all clients.

These services and local linkages between substance abuse programs and local clinics were evenly distributed statewide and involved all contracted program sites. All clients received a HIV/STD/TB/Hepatitis Risk Assessment at admission to treatment and appropriate referrals were made. Pre and post test counseling, testing and HIV education was available to clients in substance abuse treatment.

A Treatment Specialist from ADA maintained continued contact with contracted agencies and coordinated technical assistance education. A qualified contracted provider conducted regional trainings for treatment providers regarding HIV Prevention and Pre/Post Test Counseling. Additional services were provided to by the Department of Mental Health, Office of Medical Affairs in the form of technical assistance and consultation. ADA adhered to the protocols established by the U. S. Centers for Disease Control and Prevention and DHSS.

The responsibility for public health and communicable diseases is a secondary role, requiring close coordination of policy and program priorities between the DHSS and ADA.

ADA has a current Memorandum of Understanding (MOU) with DHSS which identifies a working understanding related to prevention of communicable disease. This MOU identifies that ADA will continue to collaborate with DHSS to strengthen community access to and utilization of HIV prevention and care services, STD, Hepatitis, and TB educational, screening, and treatment services. Continued technical assistance and training are planned for delivery to all regions in the state as stated in the current MOU between DHSS and ADA.

Missouri

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25 and 45 C.F.R. 96.129). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2004 (Compliance): (participation OPTIONAL)

FY 2006 (Progress): (participation OPTIONAL)

FY 2007 (Intended Use): (participation OPTIONAL)

FY 2004 (Compliance)

In FY 2004, the Department of Mental Health, Division of Alcohol and Drug Abuse, opened three (3) women and 2 men's Oxford Houses. A continued need for safe and affordable housing exists in Missouri and indications are this will be the case for many years to come. Housing specialists employed by the state continue to monitor and provide technical assistance to 46 houses for men and 12 houses for women.

FY 2006 (Progress)

The Department of Mental Health, Division of Alcohol and Drug Abuse continues to support the Oxford House program within the State of Missouri. Through careful selection of prospective house locations, the stabilization of Oxford House program has been maintained.

FY 2007 (Intended Use)

The housing needs of recovering alcoholics and substance abusers will continue to be a high priority in the future. The state of Missouri will continue to support the group home program to assure adequate housing for individuals completing treatment and seeking safe and affordable housing. The Department of Mental Health, Division of Alcohol and Drug Abuse, will continue to assist in opening new housing and providing technical assistance to the Oxford House program.

Missouri

Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25; 45 C.F.R. 96.129; and 45 C.F.R. 96.122(f)(1)(vii))

If the State has chosen in Fiscal Year 2004 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2004 to establish group homes for recovering substance abusers. In a narrative of up to two pages, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years' operations.

Attachment F

The Anti-Drug Abuse Act of 1988 (Pub. I. 100-690, approved November 18, 1988) amended Subpart I of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x) by adding a new section 1916A establishing a program entitled Group Homes for Recovering Substance Abusers.

Under the Alcohol and Drug Abuse and Mental Health Services (ADMS) Block Grant, the Missouri Department of Mental Health (DMH) established the Group Home Revolving Loan fund by contract with the Missouri Housing Development Commission (MHDC) effective August 11, 1989. In 2002, the DMH contracted with Oxford House, Inc. to manage the Revolving Loan Fund. States were required to establish the revolving fund in the amount of $100,000. States must establish, directly or through the provision of a grant or contract to a non-profit entity, a revolving loan fund.

By law, individual loans for the establishment of programs to provide housing may not exceed $4,000 each. The loans are to be repaid within a 2 year period. These funds are to be used to provide start-up loans to groups of recovering individuals.

As stipulated in accordance with the specifications in the Block Grant legislation, the loans have specific requirements. An application must be submitted to the DMH and signed by at least six recovering individuals who have completed alcohol and/or drug treatment. They must want to start a self-run, self-supported alcohol and drug free house. After reviewing the application, the DMH forwards the application to Oxford House World Services where a review is completed; a check is then forwarded to the applicant (borrower). Loan checks are not made payable to individuals but in the name of the house which is designated by the name of the street or town where it is located. Loan repayment schedules are in 12, 18, or 24 month installments. No loan payments are due for the first 30 days after the original loan is issued. No interest is charged to the borrower on the principal on the loan. Repayments are made to Oxford House World Services where they are deposited into the revolving loan fund. Late payments from the borrower are assessed a 20% or $25.00 if not received as scheduled.

There were five (5) loans issued in 2004 totaling $15,400. The amount of funds available at the time of these loans was between $11,903 and $34,000. Other existing loans were being repaid while new loans were approved to open the new houses. A monthly report is forwarded by Oxford House World Services giving details for each loan and payment schedule. Every house that has a loan receives a payment book and is contacted if scheduled payments are late or have not been received. There have been instances of late payments or loan defaults during the past year due to vacancies, unexpected increases in utility bills, house closings, or changes in the house such as switching form a men to women's house. When payment issues arise, a letter is sent to the house reminding them of their payment obligations. In cases where a house closes, the loan is reassigned to the Oxford House Chapter or another house until the loan is repaid.

On a monthly basis the Oxford House Drug Free Group Home Specialist receives the loan report from Oxford House World Services detailing the activity of every house. Any house experiencing financial difficulty is contacted and counseled by the Drug Free Group Home Specialist who is employed by the DMH. Technical assistance is provided by the Drug Free Group Home Specialist and can be contacted through an 800 telephone number. There are two individuals who are employed by the DMH that comprise this team. Through publications, meetings and workshops the Division of Alcohol and Drug Abuse has made education of the Oxford House concept a priority for legislators, communities, and local government agencies throughout Missouri.

As of June 30, 2004, 106 loans have been committed in Missouri for drug-free group homes. These homes are located in 15 Missouri cities. More than $329,000 has been loaned to open Oxford Houses in Missouri since 1989. There are 58 houses in the state where 365 men and 73 women make their home.

Missouri was one of a few states that initially welcomed the Oxford House program when it was first offered. Since that time, Missouri has seen its share of successes and failures. Because it has been through the good and tough times, Missouri recognizes the value of continuing to provide safe and affordable housing programs for individuals after their completion of substance abuse treatment.

CENTRAL REGION

Alhambra
107 E. Alhambra
Columbia, MO 65203
M 573-443-2640

Bicknell
104 Bicknell
Columbia, MO 65203
M 573-442-7084

Calico
2504 Calico St.
Columbia, MO 65202
M 573-474-0035

Cougar
600 Rogers St.
Columbia, MO 65203
M 573-442-2330

Hubble
105 Hubble St.
Columbia, MO 65201
W 573-499-0202

Leslie
19 E. Leslie
Columbia, MO 65202
M 573-256-5221

Nelwood
2501 Nelwood Dr.
Columbia, MO 65202
M 573-814-0888

Pioneer
1213 Pioneer St.
Columbia, MO 65202
M 573-886-9550

Proctor
314 Proctor Dr.
Columbia, MO 65202
M 573-874-9610

Quail
2614 Quail St.
Columbia, MO 65202
M 573-814-3900

Elliott
220 Elliott Ave.
Columbia, MO 65201
W 573-256-8501

Sondra
921 Sondra
Columbia, MO 65203
M 573-875-5721

Spring Valley
338 Crown Point
Columbia, MO 65203
W 573-443-3571

Willowbrook
2501 Willowbrook Ct.
Columbia, MO 65203
M 573-474-0741

EASTERN REGION

Allendale
3127 Meramec St.
St. Louis, MO 63118
M 314-353-5823

Chippewa
6408 Chippewa
St, Louis, MO 63109
M 314-353-2771

Clayton
6957 Clayton Rd.
St. Louis, MO 63110
M 314-863-7669

Fairview
2171 Hwy. 61
Festus, MO 63028
M 636-937-2514

Fountain
4328 Delmar
St. Louis, MO 63108
M 314-535-0734

Gravois
3943 Gravois
St. Louis, MO 63116
M 314-772-1303

Humphrey
3542 Humphrey
St. Louis, MO 63118
M 314-865-2928

Jarman
4506 S. Grand
St. Louis, MO 63118
W 314-351-1567

Kensington
5058 Kensington
St. Louis, MO 63108
M 314-367-7962

Lindbergh
1655 Fairmount Dr.
Florissant, MO 63138
M 314-839-4180

Lusher
11876 Lusher Rd.
Florissant, MO 63138
M 314-741-7536

McCausland
2017 McCausland
St. Louis, MO 63143
M 314-644-0971

McDonough
527 McDonough
St. Charles, MO 63303
M 636-947-6730

Michigan
7127 Michigan Ave.
St. Louis, MO 63111
M 314-351-2712

Monitor
3633 Meramec
St. Louis, MO 63116
W 314-752-1213

Montana
3633 Montana
St. Louis, MO 63116
M 314-351-2064

Oak Lake
11100 Oak Lake Ct.
Creve Coeur, MO 63147
W 314-432-5514

Osage
2715 Osage St.
St. Louis, MO 63118
W 314-772-6771

Portis
4430 Arsenal
St. Louis, MO 63118
M 314-776-7076
314-776-5825

Shenandoah
720 Shenandoah
St. Louis, MO 63104
M 314-776-4883

St. Charles
225 N. 5th St.
St. Charles, MO 63301
M 636-940-0741

Winfield
60 Frankie Dr.
Winfield, MO 63389
M 636-566-6258

WESTERN REGION

Blue Hills
1832 E. 49th St.
Kansas City, MO 64130
M 816-921-1012

Brookwood Avenue
5123 Brookwood Ave.
Kansas City, MO 64110
W 816-861-2176

Felix
1419 Felix
St. Joseph, MO 64501
M 816-232-4773

Harrison
26 E. Concord
Kansas City, MO 64112
M 816-237-1925

Hillcrest
9719 Hillcrest Rd.
Kansas City, MO 64134
M 816-761-3948

Holmes
2741 Holmes
Kansas City, MO 64108
M 816-842-1634

Karnes
3734 Walnut Ave
Kansas City, MO 64109
W 816-931-6731

Marlboro
1410 E. 77th Terrace
Kansas City, MO 64131
M 816-333-2267

Museum Hill
1210 Felix
St.Joseph, MO 64501
W 816-676-2323

Northeast
1229 Benton Blvd.
Kansas City, MO 64127
M 816-231-8086

Rockhill
5632 Charlotte
Kansas City, MO 64110
M 816-822-7134

St. Joseph
507 S. 10th
St. Joseph, MO 64501
M 816-232-8988

Truman
400 S. Hocker
Independence, MO 64050
M 816-833-0222

SOUTHWESTERN REGION

Catalina
1674 S. Catalina
Springfield, MO 65807
M 417-887-7783

Grant Street
2555 N. Grant St.
Springfield, MO 65803
M 417-863-0244

Hynes
307 Hynes St.
West Plains, MO 65775
M 417-257-0157

United
3215 E. Southern Hills
Springfield, MO 65807
M 417-866-1183

Kerr
953 W. Kerr
Springfield, MO 65803
M 417-864-6316

Moffet
529 Moffet St.
Joplin, MO 65801
M 417-623-4347

Mount Branson
1154 East Hwy. 76
Branson, MO 65616
M 417-334-4696

Pierce
805 E. Dale
Springfield, MO 65803
W 417-866-1126

Wall
1422 S. Wall Ave.
Joplin, MO 65616
W 417-623-8984

TECHNICAL ASSISTANCE STAFF

1/800-575-7480 ADA Toll Free Number

Jacquie Lockett
314/877-0386

David Cikesh
816/482-5763

M = Men
W = Women
W/C = Women & Children

Missouri

Goal #8: Tobacco Products

GOAL # 8. An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).

- Is the State's FY 2007 Annual Synar Report included with the FY 2007 uniform application?
  Yes No
- If No, please indicate when the State plans to submit the report:
  mm/dd/2006

Note: The statutory due date is December 31, 2006.

Yes, the State of Missouri included its submission of the annual Synar Report with the FY 2007 uniform application.

Missouri

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

The Missouri Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) has developed specialized Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs for women and children. ADA certification standards and provider contracts require that pregnant and postpartum women be given admission priority. Monitoring procedures are in place to assist pregnant women in accessing treatment as quickly as possible. Agency activity levels are monitored at the regional level through the District Administrators and Area Treatment Coordinators. The information system designed and maintained by the DMH has a registration option of screening/waiting rather than admission. ADA encourages each provider to maintain contact with those clients on their waiting list by providing interim treatment services until services at the appropriate level of care are available. Agencies within close proximity of each other have developed informal telephone communications to refer clients to other programs when they are unable to meet the needs of those clients seeking treatment. This has proven to be an effective process. Also, ADA assists agencies in locating treatment services throughout the state. ADA has a toll-free number advertised for consumers to call for referrals. Central office or regional staff receive the calls and make referrals to treatment programs in the consumer's area. Compliance was monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

FY 2006 (Progress)

Pregnant women continue to receive admission priority as required by provider contacts and certification standards. Compliance continues to be monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff. The results of this monitoring activity demonstrate that pregnant women are being admitted to treatment and receiving services as required.

FY 2007 (Intended Use)

Pregnant women will continue to receive admission priority as required by provider contract and certification standards. Missouri continues to utilize the Access to Recovery Grant which provides additional treatment resources and assures pregnant women will continue to be admitted immediately upon presenting themselves for treatment. Compliance will continue to be monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

Missouri

Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2005) to the fiscal year for which the State is applying for funds:

In up to five pages, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of procedures may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of activities may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

Attachment G

The Single State Agency for the State of Missouri addresses the requirements for developing capacity management and waiting list systems for intravenous drug users and pregnant women through several methods:

1. Certification Standards for Alcohol and Drug Abuse Programs

The capacity management systems for the Division of Alcohol and Drug Abuse (ADA) are addressed in standards which guide providers of treatment services through the Certification Standards for ADA programs. These Certification Standards are codified as state regulations in the Code of State Regulations (CSR) and filed with the Missouri Secretary of State. Relevant standards include:

9 CSR 10-7.030 (1) (Service Delivery Process and Documentation) requires each individual requesting service shall have prompt access to a screening in order to determine eligibility and plan an initial course of action, including referral to other services and resources, as needed.

(A) At the individual's first contact with the organization (whether by telephone or face-to-face contact) any emergency or urgent service needs shall be identified and addressed.

1. Emergency service needs are indicated when a person presents a likelihood of immediate harm to self or others. A person who presents at the program site with emergency service needs shall be seen by a qualified staff member within fifteen (15) minutes of presentation. If emergency service needs are reported by telephone, the program shall initiate face-to-face contact within one (1) hour of telephone contact or shall immediately notify local emergency personnel capable of promptly responding to the report.
2. Urgent service needs are indicated when a person presents a significant impairment in the ability to care for self but does not pose a likelihood of immediate harm to self or others. A person with urgent service needs shall be seen within forty-eight (48) hours, or the program shall provide information about treatment alternatives or community supports where available.
3. Routine service needs are indicated when a person requests services or follow-up but otherwise presents no significant impairment in the ability to care for self and no apparent harm to self or others. A person with routine service needs should be seen as soon as possible to the extent that resources are available.

(B) The screening shall include basic information about the individual's presenting situation and symptoms, presence of factors related to harm or safety, and demographic and other identifying data.

(C) The screening—

1. Shall be conducted by trained staff;
2. Shall be responsive to the individual's request and needs; and
3. Shall include notice to the individual regarding service eligibility and an initial course of action. If indicated, the individual shall be linked to other appropriate services and resources in the community.

9 CSR 30-3.190 (1) (Specialized Program for Women and Children) requires that in programs that provide treatment solely to women and children, priority is given to women who are pregnant or postpartum.

9 CSR 10-7.010 (6) (Treatment Principles and Outcomes) requires (A) Services and supports shall be provided in the most appropriate setting available, consistent with the individual's safety, protection from harm, and other designated utilization criteria and (7) Essential Treatment Principle—Array of Services.

(A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.
2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.
3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.
4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.
5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals.

9 CSR 30-3.100 (14) (Services Delivery Process and Documentation) requires that the Division of Alcohol and Drug Abuse conduct clinical review to "promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definition."

9 CSR 30-3.132 (5) (Opioid Treatment Program) requires "the program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive."

Agencies within close proximity of each other have developed informal telephone communications to refer clients to other programs when they are unable to meet the needs of those clients seeking treatment. This has proven to be an effective process. Also, the Division of Alcohol and Drug Abuse assists agencies in locating referral resources throughout the state.

Funds Expended or Obligated for the Federal Fiscal Year two years prior to the year for which the State is applying for funds:

These certification standards are part of the ongoing operations of the Missouri Division of Alcohol and Drug Abuse (ADA). In addition, the statewide network of treatment providers offer an easy vehicle for communication across provider agencies on topics related to treatment capacity. No direct costs can be attributed to complying with the capacity management and waiting list requirements of the block grant.

2. Information systems: Client Tracking, Registration, Admission, and Commitment (CTRAC)

The CTRAC information system designed and maintained by the Missouri Department of Mental Health (DMH) has a registration option of screening/waiting rather than admission. ADA allows each provider to maintain contact with those clients on their waiting list in the manner each provider determines best or appropriate for their particular agency.

Funds Expended or Obligated for the Federal Fiscal Year two years prior to the year for which the State is applying for funds:

CTRAC is a component of the DMH's client information infrastructure. Costs for complying with block grant capacity management and waiting list requirements are part of the ongoing costs of this infrastructure and cannot be estimated.

3. Toll-free Telephone Number

ADA has a toll-free number advertised for consumers to call in for referrals. Either central office or regional staff receive the calls and make referrals to treatment programs in the consumer's area.

A long standing policy of ADA has been to prioritize the admission and treatment of pregnant women and intravenous drug users. These consumers are not placed on a waiting list for treatment. When members of these priority populations present for service they are promptly screened, assessed, and engaged in the level and intensity of care that is commensurate with their clinical needs. While treatment services at any level and intensity can be immediately available to members of these populations, agencies offering the residential component do not always have beds available. In such situations the ADA policy has required the agency to transition a clinically stable consumer who is not a member of a priority population from residential support to transitional or supportive housing or other appropriate housing plan, thereby ensuring room in the residence for the priority population consumer.

The above procedure has worked reasonably well in light of limited resources. During the next fiscal year, ADA plans to amend the standards to expressly require the implementation of the above procedure. Compliance with this procedure will be monitored by Certification Surveys and annual Safety and Basic Assurance Reviews utilizing the Block Grant Compliance Checklist and technical assistance visits by district staff.

ADA does not identify costs separately for capacity management and waiting list systems; these costs are included in our administrative costs.

Missouri

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

Data from the St. Louis Targeted Cities program permitted Missouri's Department of Mental Health (DMH), Division of Alcohol and Drug Abuse (ADA) a unique opportunity to evaluate the quality of client agency matching, client progress in treatment, and treatment outcomes. The standard computerized client assessment tool developed during this grant, Initial Standardized Assessment Protocol (ISAP), has enhanced the ability of providers and ADA to perform three important functions. The ability to identify the most appropriate intensity level of care for each client is enhanced. Data collection enabling utilization review and outcome measures is now possible. Comprehensive identification of problem areas for treatment planning is also enhanced. All treatment providers statewide have been trained to use the ISAP. The ISAP contains separate assessments for adult and adolescent clients.

The Addiction Severity Index (ASI) is the primary assessment tool used to determine level of care for clients age eighteen years and older. The ASI is a structured clinical interview which is typically conducted in less than fifty minutes at the time of the client's admission. This assessment tool encompasses seven areas of life function: medical status; employment status; drug and alcohol use; family history; family and social relationships; legal status; and psychiatric status.

The Missouri Adolescent Comprehensive Substance Assessment (MACSA) was designed by a workgroup of Missouri adolescent treatment providers. The MACSA is a structured clinical interview which is typically conducted at the time of the adolescent's admission to treatment. This assessment tool encompasses seven areas of life function: legal, school and work; behavior and emotions; friends; family; recovery environment and placement.

All providers are using the ISAP and either batching information or using the internet virtual private network to input the data directly to a data warehouse for information retrieval by ADA. ADA staff review utilization data on an agency-by-agency basis to identify major trends, problem areas, and successful outcomes. Providers are utilizing the computerized ISAP to assure clients are provided the most appropriate level of care. The tool permits greater ability to perform utilization review and outcome measurement.

Certification standards require individuals to meet eligibility criteria for admission into each level of the continuum of care.

9 CSR 30-3.120 Detoxification
(3) Eligibility Criteria: In order to be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. A person qualifies for detoxification services on a residential basis if one or more of the following additional criteria are met:

(A) Demonstrates a current inability to minimally care for one self;
(B) Lacks a supportive, safe place to reside and demonstrates a likelihood of continued use of alcohol or other drugs;
(C) Requires ongoing observation and monitoring of vital signs due to a prior history of physical complications associated with withdrawal or the severity of current symptoms of intoxication, impairment or withdrawal; or
(D) Presents a likelihood of harm to self or others as a result of intoxication, impairment or withdrawal.

9 CSR 30-3.140 Residential Treatment
(2) Eligibility Criteria: In order to fully participate in and benefit from the intensive set of services offered in residential treatment, a person must meet the following admission and eligibility criteria:
(A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. A screening instrument, that includes vital signs, must be used with all prospective clients to identify symptoms of intoxication, impairment, or withdrawal and, when indicated, detoxification services must be provided or arranged;
(B) Needs an alternative, supervised living environment to ensure safety and protection from harm;
(C) Meets the general treatment eligibility requirement of a current diagnosis of substance abuse or dependence and, in addition, demonstrates one or more of the following:
1. Recent patterns of extensive or severe substance abuse;
2. Inability to establish a period of sobriety without continuous supervision and structure;
3. Presence of significant resistance or denial of an identified substance abuse problem; or
4. Limited recovery skills and/or support system; and
(D) A client may qualify for transfer from outpatient to residential treatment if the person:
1. Has been unable to establish a period of sobriety despite active participation in the most intensive set of services available on an outpatient basis; or
2. Presents imminent risk of serious consequences associated with substance abuse.

9 CSR 30-3.130 Outpatient Treatment
(4) Community-Based Primary Treatment: This level of care is the most structured, intensive, and short-term service delivery option. Structured services shall be offered at least five (5) days per week and should approximate the service intensity of residential treatment.
(A) Eligibility for primary treatment shall be based on:
1. Evidence that the person cannot achieve abstinence without close monitoring and structured support; and
2. Need for frequent, almost daily services and supervision.

(5) Intensive Outpatient Rehabilitation: This level of care offers an intermediate intensity and duration of treatment. Services should be offered on multiple occasions during each week.

(A) Eligibility for intensive outpatient rehabilitation shall be based on:

1. Ability to limit substance use and remain abstinent without close monitoring and structured support;
2. Absence of crisis that cannot be resolved by community support services;
3. Evidence of willingness to participate in the program, keep appointments, participate in self-help, etc.; and
4. Willingness, as clinically appropriate, to involve significant others in the treatment process, such as family, employer, probation officer, etc.

(6) Supported Recovery: This level of care offers treatment on a regularly scheduled basis, while allowing for a temporary increase in services to address a crisis, relapse, or imminent risk of relapse. Services should be offered on approximately a weekly basis, unless other scheduling is clinically indicated.

(A) Eligibility for supported recovery shall be based on:

1. Lack of need for structured or intensive treatment;
2. Presence of adequate resources to support oneself in the community;
3. Absence of crisis that cannot be resolved by community support services;
4. Willingness to participate in the program, keep appointments, participate in self-help, etc.
5. Evidence of a desire to maintain a drug-free lifestyle;
6. Involvement in the community, such as family, church, employer, etc.; and
7. Presence of recovery supports in the family and/or community.

9 CSR 30-3.132 Opioid Treatment Program

(5) Admission Criteria: The program shall provide treatment and rehabilitation, which includes the use of methadone, to those persons who demonstrate physiologic dependence to heroin and other morphine-like drugs. Priority for admission shall be given to women who are pregnant and to persons who are Human Immunodeficiency Virus (HIV) positive. Persons who are not residents of the state of Missouri shall comprise no more than twenty percent (20%) of the clients of the program.

(A) In order to qualify for medically supervised withdrawal, the applicant must demonstrate physiologic dependence to narcotics. Documentation must indicate clinical signs of dependence, such as needle marks, constricted or dilated pupils, etc.

(B) In order to qualify for initial admission to ongoing opioid treatment, the applicant must demonstrate physiologic dependence and continuous or episodic addiction for the one (1)-year period immediately prior to application for admission. Documentation must indicate clinical signs of dependence, past use patterns and treatment history, etc. The following exceptions may be made to the minimum admission requirements for opioid treatment:

1. The program may place a pregnant applicant on a methadone treatment regimen, regardless of age, if the applicant has had a documented dependency on heroin or other morphine-like drugs in the past and may be in direct jeopardy

of returning to such dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiologic dependence if a program physician certifies the pregnancy and, in his/her reasonable clinical judgment, justifies opioid treatment;

2. For an applicant who is under the age of eighteen (18), the program shall document two (2) unsuccessful attempts at drug-free treatment prior to admission to ongoing opioid treatment. The program shall not admit any person under the age of sixteen (16) to a program without the prior approval of the Division of Alcohol and Drug Abuse; and

3. An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a program within fourteen (14) days before release or discharge or within six (6) months after release from such an institution without evidence of current physiologic dependence on narcotics provided that prior to institutionalization the client would have met the one (1)-year admission criteria.

(C) In order to qualify for readmission to opioid treatment, the applicant must demonstrate current physiologic dependence.

1. The program may waive this requirement if it documents prior opioid treatment of six (6) months or more and discharge within the past two (2) years.

2. At the discretion of its medical director, the program may require an applicant who has received administrative detoxification due to an infraction of program rules to wait a minimum of thirty (30) days prior to applying for readmission.

(D) The medical director may refuse the admission of an applicant and/or opioid treatment to a particular client if, in the reasonable clinical judgment of the medical director, the person would not benefit from such treatment. Prior to such a decision, appropriate staff should be consulted and the reason(s) for the decision must be documented by the medical director.

ADA's Clinical Utilization Review Unit makes determinations regarding the appropriate level of care for consumers according to certification standards.

(14) Clinical Utilization Review: Services are subject to clinical utilization review when funded by the department or provided through a service network authorized by the department. Clinical utilization review shall promote the delivery of services that are necessary, appropriate, likely to benefit the client, and provided in accordance with admission criteria and service definitions.

(A) The department shall have authority in all matters subject to clinical utilization review including client eligibility and service definition, authorization, and limitations.

(B) Any service matrix or package that is developed by the department or its authorized representative shall include input from service providers.

(C) Clinical utilization review shall include, but is not limited to, the following situations regarding an individual client:

1. Length of stay beyond any specified maximum time period;
2. Service authorization beyond any specified maximum amount or cost;
3. Admission of adolescents into adult programs; and

4. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA.

(D) Clinical utilization review may be required of any client's situation and needs prior to initial or continued service authorization.

(E) The need for clinical utilization review may be identified and initiated by a provider, an individual client, or by the department.

(F) Clinical utilization review may include, but is not limited to, the following situations regarding a program:

1. Unusual patterns of service or utilization, based on periodic data analysis and norms compiled by ADA regarding the utilization of particular services and total service costs; and

2. Compliance issues related to certification standards or contract requirements that can reasonably be monitored through clinical review.

(15) Credentialed Staff: Clinical utilization review shall be conducted by credentialed staff with relevant professional experience.

The Division of ADA maintains contracts with Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs throughout the state to provide specialized services to populations including women and children, and adolescents. The CSTAR specialized programs for women and children provide treatment, rehabilitation, and other supports solely to women and their children. These programs focus on therapeutic issues relevant to women including parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality. The women's CSTAR programs also provide or arrange daycare and therapeutic services for children who accompany their mother in treatment. The CSTAR specialized programs for adolescents provide treatment, rehabilitation, and other services solely to clients between the ages of twelve and seventeen inclusive and their families. These programs focus on therapeutic issues relevant to adolescents including recovery issues such as peer relationships, use of leisure time, and abuse and neglect; skill development such as decision-making and study skills; and information and education regarding adolescent developmental issues and sexuality. The adolescent CSTAR programs also have an emphasis on family support and involvement, as appropriate.

FY 2006 (Progress)

The Internet web based version of the Initial Standardized Assessment Protocol (ISAP) with data transported over a Virtual Private Network for confidentiality has become the only Department of Mental Health (DMH) supported version of the assessment. Contracted agencies are using the Internet version of the ISAP called the "Outcomes Web".

Eligibility criteria contained within certification standards have been maintained. The Clinical utilization review unit continued to review service plans for compliance with certification standards, appropriateness of placements in the continuum of care consistent with ISAP assessment and acceptable standards of care.

The Division of Alcohol and Drug Abuse (ADA) maintains contracts with Comprehensive Substance Treatment and Rehabilitation (CSTAR) programs throughout the state to provide specialized services to populations including women and children, and adolescents. During FY 2006, there were 11 women and children's CSTAR and eight adolescent CSTAR agencies providing these specialized services in Missouri.

During FY 2006, adolescent CSTAR providers were trained and certified by Chestnut Health Systems in Illinois to administer and train other agency staff members to use the Global Assessment of Individual Needs (GAIN) assessment instrument. This is a research-backed full bio-psycho-social assessment that integrates research and clinical assessment to complete diagnosis, placement, individualized treatment planning, program evaluation, and reporting requirements. The GAIN will provide a comprehensive, standardized tool with which to ensure appropriate placement and referrals.

Missouri was among 14 states and one tribal organization to be awarded an Access to Recovery (ATR) grant from the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration. The Office of the Governor was awarded $7.6 million for each of three grant years for a total of $22.8 million. The Governor has designated ADA to administer grant funds. The ATR program was fully implemented April 1, 2005. On this date, additional primary treatment programs were converted to Community Based Primary Treatment programs offering a continuum of treatment services based on the client's assessed needs.

ATR grants are intended to assist recipients in designing and implementing a voucher program to pay for an expanded array of community-based clinical substance abuse treatment and recovery supports. Keys to successful implementation of the ATR grant are to ensure genuine, free, and independent client choice of appropriate clinical substance abuse treatment and recovery supports.

The ATR funds will help to enhance all existing primary recovery programs to provide the full array of services including multiple levels of care and trauma services. In some cases, ADA will issue Requests for Proposals to expand services into areas that are underserved and in others they will credential nontraditional and faith-based organizations to provide recovery support services in their communities. Specific recovery support services available from credentialed nontraditional and faith-based organizations through the Access to Recovery Grant include care coordination, childcare, drop-in center, emergency/temporary housing, family engagement, pastoral counseling, individual and group recovery support, spiritual life skills, and transportation. During FY 2006, a total of 95 recovery support providers across the state were credentialed to provide services in conjunction with primary recovery treatment programs. Since the start of the ATR grant, a total of 104 recovery support providers have been credentialed.

FY 2007 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to review utilization data to identify patterns of success by agency. ADA is working on fine-tuning the ability to retrieve data in a meaningful fashion. ADA will continue to implement the outcomes measurement plan and assure reliable outcomes data is being collected to meet the federal requirements.

The clinical utilization review unit will continue to review service plans for compliance with certification standards, appropriateness of placements in the continuum of care consistent with Initial Standardized Assessment Protocol assessment and acceptable standards of care.

An evaluation protocol will continue to track clients while they are engaged in treatment and after discharge to ensure that programs are demonstrating their treatment is effective and leads to recovery. Treatment effectiveness will be measured by seven outcome domains, including: 1) retention in treatment; 2) abstinence from alcohol and drug use; 3) no involvement with the criminal justice system; 4) attainment of employment or enrollment in school; 5) stable family and living conditions; 6) access and capacity to treatment; and, 7) involvement in the social supports of recovery.

All data collected to meet reporting requirements and conduct longitudinal outcome evaluation will be incorporated into the Customer Information Management, Outcomes, and Reporting (CIMOR) system. All service providers will be required to collect and enter this information into the CIMOR system. The Missouri Institute of Mental Health will continue to serve as the contractor to collect data for the Access to Recovery project.

The Global Assessment of Individual Needs (GAIN) assessment instrument will be fully implemented across all adolescent CSTAR programs in FY 2007. Continued training and support for the implementation of this assessment will be provided by GAIN-certified ADA and MIMH staff.

Missouri

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

The Missouri Department of Mental Health's (DMH) annual Spring Training Institute was held May 19-21, 2004 with 981 professionals from the substance abuse prevention and treatment fields in attendance. National and local experts presented on a range of topics including co-occurring disorders, trauma and domestic violence, drug court, treatment planning for successful community outcomes, effective models for prevention in the treatment setting, and others.

The Division of Alcohol and Drug Abuse (ADA) treatment staff developed a series of training modules that were delivered to treatment and prevention providers throughout the state. These sessions were tailored to meet the needs of the staff in each agency. Over 80 on-site workshops were conducted during this fiscal year including Motivational Interviewing, Documentation, Treatment Planning, Confidentiality and Alcohol and Drug Federal Regulations, Addiction Ethics, Peer Review, Collaborative Model, and Outcomes Web Assessment. ADA provided training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders. The training focus included community assessments, capacity building, and measurable outcomes

ADA provided training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance was provided to promote community development, accountability, and targeted prevention initiatives based on the Center for Substance Abuse Prevention's (CSAP) best practices program recommendations. ADA consistently collaborated with CSAP's Southwest Center for the Application of Prevention Technology to provide training and technical assistance for targeted prevention initiatives. ADA contracted with Development Systems, Inc. to provide five regional HIV pre- and post-test counseling trainings to substance abuse provider staff. The Missouri Department of Health and Senior Services has reviewed this curriculum and found it to meet the federal guidelines established by the Centers for Disease Control and Prevention.

FY 2006 (Progress)

The Department of Mental Health's annual Spring Training Institute was held May 17-19, 2006 and attended by over 880 professionals from the substance abuse prevention, substance abuse treatment, and mental health fields. The theme of the conference was *Advancing Our Knowledge*. National and local experts shared information about a wide range of evidence based practices including trauma and disaster situations, National Outcomes Measures, cognitive-behavioral treatment issues, opioid pharmacotherapy, fetal alcohol spectrum disorders, motivational interviewing, faith-based treatment practice, and Missouri's methamphetamine problems. The Missouri Division of Alcohol and Drug Abuse (ADA) Clinical Services Team provided technical assistance and training sessions to treatment providers including the clinical review process, accessing services, the certification process and documentation. ADA Access To Recovery (ATR) staff developed a series of trainings that were presented to Missouri's treatment and recovery support providers, with sessions tailored to meet the needs of the staff in each agency. ATR staff conducted 30 on-site training sessions during the fiscal year including: Government Performance and Results Act interview tool, ATR Overview, ATR Voucher Management, Clinical Supervision, Confidentiality, Ethics, Addictions Academy, and Motivational Interviewing.

ADA continued to provide training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance concerning community development, accountability, and targeted prevention initiatives were based on Center for Substance Abuse Prevention's (CSAP) best practices program recommendations. ADA has continued its close collaboration with Southwest Center for the Application of Prevention Technology (SWCAPT) to provide training and technical assistance for targeted prevention initiatives. The SWCAPT was designated to provide technical assistance to the Workforce Development Committee, known as the Missouri Prevention Network, to identify core competency requirements for levels of certification for prevention professionals. The SWCAPT will also provide technical assistance to support the implementation of the Strategic Prevention Framework State Incentive Grant (SPFSIG). The SWCAPT position became vacant in March 2006, and is expected to be filled in FY2007. ADA regional prevention specialists provide technical assistance and training to the Missouri School-based Prevention Intervention Resources Initiative (SPIRIT) programs to assist with their implementation of science-based interventions.

Regional Collaborative Model cross-training was continued in partnership with the Department of Health and Senior Services (DHSS) to reduce incidence of blood borne and sexually transmitted diseases among ADA clientele**.** All regions will receive Hepatitis training and updated Hepatitis curricula in the fall of 2006 to strengthen their capacity to reduce the spread of blood borne and sexually transmitted diseases. ADA contracted with Development Systems, Inc. to provide five regional HIV pre- and post-test counseling trainings to substance abuse provider staff. The DHSS approved this training curriculum as identified by the Centers for Disease Control and Prevention. Under the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project

initiative with the DHSS, selected women and children's Comprehensive Substance Treatment and Rehabilitation (CSTAR) providers will receive training and technical assistance to provide the Fetal Alcohol Syndrome (FAS) model of risk reduction to participating female consumers, and to continue to effectively conduct screening for FAS. Continued in-service training for screening of FAS children has been encouraged with provision of FAS training videos to each participating CSTAR provider.

FY 2007 (Intended Use)

The Department of Mental Health's annual Spring Training Institute will be held May 16-18, 2007. Continued collaboration with Mid-America Addiction Technology Transfer Center, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention will ensure that employees of treatment and prevention agencies in Missouri receive training and education to promote the use of evidence-based practices. Division of Alcohol and Drug Abuse (ADA) Access to Recovery (ATR) staff will continue to provide training to treatment and recovery support providers throughout the state. In the coming year these sessions will train providers to use the Government Performance and Results Act (GPRA) interview tool and the ATR Voucher Management system.

ADA will continue to provide training, education, and technical assistance through the Missouri Substance Abuse Prevention Resources Network. Training and technical assistance will be focused on community development, accountability, and targeted prevention initiatives and will follow CSAP's best practices program recommendations. The Southwest Center for the Application of Prevention Technology (SWCAPT) will continue to provide technical assistance to ADA to support the implementation of Missouri's Strategic Prevention Framework State Incentive Grant (SPFSIG) as prevention providers and community coalitions respond to the requirements for data-driven targeted prevention intervention strategies. ADA will provide training through the Statewide Training and Resource Center for Regional Support Center staff and community leaders to support their capacity to respond to community level prevention efforts supported with SPFSIG. ADA regional prevention staff will continue to provide technical assistance and training to the School-based Prevention Intervention Resources Initiative (SPIRIT) programs to encourage their utilization of best practice and science-based intervention services. The ADA Clinical Services Team will continue to provide technical assistance and trainings to providers and agencies within the community.

ADA will collaborate with the Department of Health and Senior Services (DHSS) to provide HIV pre- and post-test counseling training to substance abuse provider staff. The training curriculum will meet the federal guidelines of the Centers for Disease Control and Prevention. The Collaborative Model Initiative, in partnership with the DHSS, will be continued with provision of region specific technical assistance to reduce the incidence of sexually transmitted and blood borne diseases. Regional action plans will be utilized to identify the specific training and technical assistance needs of each region. Continued cross-training will be provided in partnership with DHSS to promote provider collaboration and strengthen service delivery. Under the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project initiative with the DHSS, selected women and children's Comprehensive Substance Treatment and Rehabilitation providers will continue to receive training and technical assistance to provide the Fetal Alcohol Syndrome (FAS) model of risk reduction to participating female consumers, and to effectively conduct screening for FAS.

Missouri

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

Certification standard 9 CSR 10-7.010 Treatment Principles and Outcomes states "(7) (A) A range of services shall be available to provide service options consistent with individual need. Emotional, mental, physical and spiritual needs shall be addressed whenever applicable.

1. The organization has a process that determines appropriate services and ensures access to the level of care appropriate for the individual.
2. Each individual shall be provided the least intensive and restrictive set of services, consistent with the individual's needs, progress, and other designated utilization criteria.
3. To best ensure each individual's access to a range of services and supports within the community, the organization shall maintain effective working relationships with other community resources. Community resources include, but are not limited to, other organizations expected to make referrals to and receive referrals from the program.
4. Assistance in accessing transportation, childcare and safe and appropriate housing shall be utilized as necessary for the individual to participate in treatment and rehabilitation services or otherwise meet recovery goals.
5. Assistance in accessing employment, vocational and educational resources in the community shall be offered, in accordance with the individual's recovery goals."

Adolescent Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) program certification standard 9 CSR 30-3.192 (3) (F) requires: "Cooperation with other youth-serving agencies shall be demonstrated in order to ensure that the needs of youth in treatment are met and that services are coordinated. Coordination of service needs is critical with youth due to their involvement with other community agencies and reliance on the family, as well as the fact that substance abuse affects multiple life areas." Coordination of education for adolescent clients during treatment is required by standards. All clients in CSTAR programs are offered a Community Support Worker whose responsibilities include "activities with or on behalf of a particular client in accordance with an individual rehabilitation plan to maximize the client's adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting client independence and responsibility." The community support worker arranges, refers, and monitors services external to the CSTAR program. Each CSTAR Women and Children's program is required to provide a child care and development program for the children of women who are concurrently receiving treatment. Each center, as required in certification standards, must design appropriate services that address the following goals: building self esteem; learn to identify and express feelings; build positive family relationships; develop decision making skills; understand chemical dependency as a family illness; and learn and practice non-violent ways to resolve conflict. Each child receives an individual assessment to determine his/her needs, and appropriate intervention or referral is arranged. Children can receive individual and family therapy and group codependency counseling from qualified personnel. The mothers receive extensive weekly training on parenting skills and supervised parent/child bonding time

to practice the new skills. The women and their children receive residential support or supportive housing to assure a safe drug free environment. All women and children who enter treatment are provided health screenings by registered nurses to identify health deficits or needs for medical intervention. Close association with local health clinics provides prenatal care, immunizations and other preventive techniques to increase the well being of mothers and their children. For women receiving day treatment and outpatient services, transportation is available to and from the facility. Two of the CSTAR programs are a joint endeavor with the Missouri Department of Corrections to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction.

The Division of Alcohol and Drug Abuse (ADA) continued to work closely with the Department of Health and Senior Services (DHSS) to access current information, trends and training related to the prevention and treatment of tuberculosis in high risk groups. ADA required contracted treatment providers to maintain effective linkages with local health resources to facilitate tuberculosis screening and treatment for all clients entering treatment programs. ADA continued to work with the DHSS to maintain community linkages with contracted treatment providers to encourage effective utilization of state and community resources. Contracted treatment providers performed HIV, TB, STD, and hepatitis risk assessments for all clients. High risk clientele were provided pre-test counseling, testing referral, and post-test counseling services. ADA continued to work collaboratively with the DHSS to develop an effective Fetal Alcohol Syndrome (FAS) prevention initiative identified as the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP). ADA worked to develop public education strategies and materials to promote the implementation of this project. Five Women and Children CSTAR program sites were identified to participate in the MOFASRAPP, and staff of these programs was trained to provide interventions to women clients who volunteered to participate. The initiative also encouraged participating CSTAR providers to perform effective FAS screening for any child of a parent receiving treatment.

ADA implemented the Missouri School-based Prevention and Intervention Initiative (SPIRIT) in five school sites in Missouri, with one site located in each of the five ADA sub-state regions. The Missouri SPIRIT program provided evidence-based prevention programs to students in grades K-12 using universal, selective, and indicated preventive interventions. The curriculums used in SPIRIT included Positive Action, Life Skills Training, Peace Builders, and Reconnecting Youth.

FY 2006 (Progress)

Missouri was awarded an Access to Recovery (ATR) Grant that provides $7.6 million per year for three years to implement a statewide treatment voucher system. This will improve coordination and available alternatives among an increased number of qualified service providers; provide recovery support services through traditional, non-traditional, and faith-based organizations; and expand the existing managed care system. Faith organizations and other nontraditional providers interested in providing recovery support services under the ATR project are required to become certified by completing the Division of Alcohol and Drug Abuse (ADA) Addictions Academy. This training provides better coordination of the provision of treatment and recovery support services. ADA is also currently reviewing the system of care for individuals with co-occurring psychiatric and substance use disorders as part of the Co-Occurring State Incentive Grant. Eleven agencies are collaborating on this project.

Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) program certification standards continue to require ADA and contracted treatment and prevention providers to maintain effective working relationships with other community resources to meet the emotional, mental, physical and spiritual needs of customers. ADA has provided numerous technical assistance visits and statewide meetings of providers to facilitate creative collaborative relationships with community resources. Two CSTAR programs continue the joint endeavor with the Missouri Department of Corrections (DOC) to provide alcohol and drug treatment to women on probation and parole. The dependent children are provided child care and treatment for physical, emotional and behavioral conditions brought about by their mothers' addiction. ADA continues to collaborate with DOC on their Missouri Reentry Program which was initiated with the Transition from Prison to Community Project. The primary objective of this program is to assist transitioning offenders with effective linkages to community treatment and mental health resources.

In FY 2006, Missouri completed the Statewide Epidemiology Prevention Assessment and submitted the initial action plan to SAMHSA for approval of the proposal to coordinate the Strategic Prevention Framework State Incentive Grant (SPF SIG). SAMHSA tentatively accepted Missouri's action plan with recommended modifications. The SPF SIG team will provide preliminary implementation training for the Prevention Resource Network prior to initiation of the community Request For Proposal process, so that Network members may provide technical assistance to support and encourage effective community coalition response to these proposals.

ADA has continued the Missouri School-based Prevention and Intervention Initiative (SPIRIT). The Missouri SPIRIT program provides evidence-based prevention programs to 3908 students in grades K–12. The curricula used are Positive Action, Life Skills Training, Peace Builders, 2 Good 4 Drugs, Second

Step, and Reconnecting Youth. Prevention providers assist school personnel with identification and screening of students exhibiting problem behaviors. Missouri SPIRIT objectives are to delay onset of chemical use, decrease substance use, improve overall school performance, and reduce violence. The Missouri Institute of Mental Health provides program evaluation, collecting three types of data: individual, school or group, and program fidelity. In order to participate in the evaluation, both parental consent and student assent are required. A total of 1,585 students participated in the evaluation during FY 2006. The following measures are being used: Teacher Observation Checklist, California Healthy Kids Survey, the Missouri Student Survey and Supplemental Survey, SPIRIT Fidelity and Quality of Program Implementation Report, Youth Satisfaction Survey, and the teacher-completed SPIRIT Initiative Questionnaire. Additional data collected on individual students includes grades, achievement test results, school attendance, suspensions, violent incidents, race, age, and gender. School level data serve as indicators for each grade as a whole regardless of student participation in the evaluation.

ADA and contracted providers continue to be involved in collaborative disease prevention activities with the Department of Health and Senior Services (DHSS) including screening, risk reduction assessment and education, and treatment of active diseases. The second phase of regional collaborative model cross-training for contracted prevention and substance abuse providers and regional community health prevention and care staff was provided in October 2005. Regional action plans focused this training and technical assistance initiative to strengthen regional linkages between ADA contracted providers and DHSS contracted providers. Planning was initiated for hepatitis training in the fall of 2006 using updated HIV/STD and hepatitis curricula. Subsequent regional training and technical assistance will be provided as staff training needs are identified. ADA has continued to partner with DHSS to coordinate the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP), a five-year prevention initiative funded by the Centers for Disease Control and Prevention (CDC) to focus Fetal Alcohol Syndrome Disorder prevention services in rural counties. The CDC grant provides continuing training for staff of five Women and Children CSTAR treatment centers to provide Fetal Alcohol Syndrome screening services for women and their dependent children, and training to implement the Personal Choices intervention strategy in the fall of 2006.

FY 2007 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to require coordination of substance abuse treatment with community resources to provide additional recovery support services to meet the needs of consumers. Housing, transportation, vocational rehabilitation, education and family services will continue to be addressed in Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs. Specialized programs will continue to provide treatment for adolescents, the opiate addicted, pregnant women, and women with dependent children. These programs provide additional programming and also maintain collaborative relationships with external community agencies to provide recovery support services to meet the special needs of these populations. The Co-Occurring State Incentive Grant project will continue to identify and implement system changes to meet the needs of clients with co-occurring disorders and improve the integration of substance abuse treatment with existing mental health services.

ADA will continue to provide funding for program implementation and evaluation at the five School-based Prevention and Intervention Initiative (SPIRIT) sites. Evaluators will continue to track the number of referrals made through the project and collect a variety of other student performance data. In collaboration with the Missouri Department of Elementary and Secondary Education, ADA will continue to support the Internet-based administration of the Missouri Student Survey in all Missouri school districts. Local districts and ADA will continue to use survey results for planning and program development.

ADA will continue its collaborative partnership with the Department of Health and Senior Services (DHSS) to continue to support the Missouri Fetal Alcohol Syndrome Rural Awareness and Prevention Project (MOFASRAPP) funded by the Centers for Disease Control and Prevention. The Personal Choices prevention intervention will be available to women receiving substance abuse treatment services in five Women and Children CSTAR programs, and staff will continue to provide FAS screening for the children of the clients. ADA and contracted providers will continue to be involved in collaborative disease prevention activities with the DHSS including screening, risk reduction, assessment, education, and treatment of active diseases. ADA will continue to work with the Department of Corrections to support the Missouri Reentry Project to encourage successful community transition of offenders who require continued substance abuse treatment and mental health services.

Missouri

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

Data from Missouri's second State Treatment Needs Assessment Program (STNAP-II) was summarized and published in the 10th edition of the Status Report on Missouri's Alcohol and Drug Abuse Problems. STNAP-II was funded by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, under CSAT Grant No. 5H79 TI12229. Data from this study was used by the Division of Alcohol and Drug Abuse (ADA) to estimate treatment penetration rates, plan treatment services, and develop the ADA portion of the budget request for the Department of Mental Health's FY 2006 budget.

The 2004 Missouri Student Survey was the product of the first collaboration between the Department of Elementary and Secondary Education and ADA to develop a single survey which measured substance abuse incidence and prevalence and risk and protective factors among public school students in grades 6-12. ADA used the SmartTrack application to conduct a web-based administration of the survey that was available to all 524 Missouri school districts. The survey provided district-level and statewide data for prevention planning requirements. ADA contracted with the Missouri Institute of Mental Health to collect the data and develop a report to analyze trends in substance abuse, delinquent behavior, and risk and protective factors.

The School-based Prevention and Intervention Initiative (SPIRIT) first year report was published in January, 2004. SPIRIT was developed to delay onset and decrease use of substances, improve overall school performance, and reduce school-related violent incidents. Three classifications of data--individual, school, and program fidelity--were collected from 1,110 students.

ADA continued to develop a systematic, data driven approach to estimate statewide and regional prevention needs. The planning process broadened with the addition of the Missouri Governor's State Prevention Initiative through the award of a one-year State Incentive Planning and Development Cooperative Agreement grant by the Center for Substance Abuse Prevention (CSAP) under Grant No. 1 UD1 SP10384-01. During FY 2004, ADA also collaborated with the Governor's Office to submit an application for the Strategic Prevention Framework State Incentive Grant to provide funding for community coalitions to plan and implement data-driven prevention projects. That application was subsequently approved for CSAP funding through Grant No. 1 U79 SP11194-01 awarded in FY 2005.

FY 2006 (Progress)

Prevalence estimates from Missouri's second State Treatment Needs Assessment Program (STNAP-II) were used to allocate treatment services and to develop the Division of Alcohol and Drug Abuse (ADA) portion of the Department of Mental Health's FY 2007 budget. These estimates were also used to calculate treatment penetration rates and were provided with other treatment utilization data in the FY2005 Division Data presentation materials developed for policy makers including the state legislature.

During FY 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA) released national and state estimates from the combined 2003-2004 National Survey on Drug Use and Health (NSDUH). ADA developed tables to compare national and Missouri rates--and Missouri population estimates--for several measures and indicators from the survey. These tables were included in the 12th edition of the *Status Report on Missouri's Alcohol and Drug Abuse Problems.* Due to the availability of the NSDUH state data, ADA updated the prevalence estimates from the STNAP-II study that was conducted during the years 2000-2003. The updates reflected 1) population changes that occurred between Census 2000 (the population base used in the STNAP-II study) and 2004, and 2) the new NSDUH estimates for Missouri developed by SAMHSA's Office of Applied Studies. ADA used the estimated number of individuals with "alcohol or illicit drug dependence or abuse" as the measure of treatment need. The population adjustments in the STNAP-II estimates and the prevalence estimates from the NSDUH were combined to produce a new set of treatment need estimates for the ADA service areas and planning regions by age group, gender, and race/ethnicity.

The Missouri Department of Elementary and Secondary Education (DESE) and ADA continued to collaborate in supporting and promoting the Missouri Student Survey, an instrument that collects data on substance abuse incidence and prevalence; delinquent behavior; and risk and protective factors related to a range of health and safety issues. In the spring of 2006, ADA made the survey available over the internet to secondary school students in Missouri's 524 school districts using the SmartTrack application. ADA continued to develop a systematic, data driven approach to identify statewide and regional prevention needs using data from this survey and other assessments.

The Missouri Governor's Prevention Initiative completed the state's Strategic Prevention Plan and submitted it to the Center for Substance Abuse Prevention (CSAP) for review. The plan integrated results from three reports initiated under the Governor's Substance Abuse Prevention Initiative planning grant (SAMHSA Grant #1 UD1 SP10384-01) and the State Epidemiological Workgroup Initial Needs Assessment completed under the Missouri Strategic Prevention Framework State Incentive Grant (SPF SIG) (SAMHSA Grant #1 U79 SP11194-01).

A Request for Proposals was under development to distribute the SPF SIG funds to community coalitions, with grant awards anticipated by October 2006. A maximum of 15 communities are expected to be funded to address local intervening variables related

to the state's priority issue of risky drinking (binge and underage) among young people ages 12-25. Funding will be distributed on the basis of high need, regional equity, and coalition capacity. Six-month planning contracts of up to $45,000 to complete the first three requirements of the SPF SIG (assessment, capacity building, and planning) will be followed by additional program implementation funding, with a maximum $125,000 per year for three years available for each site for prevention program planning and implementation.

In March 2006, ADA published the third-year report of its School-based Prevention and Intervention (SPIRIT) initiative. The evaluation component of SPIRIT uses three instruments to measure the progress of children and youth as a result of the program. Children in grades K-3 are assessed by teachers using a form that measures changes in aggression and social skills. Students in grades 4–5 complete an approved, localized version of the California Healthy Kids Survey, which assesses risk and protective factors related to adolescent substance use. Students in grades 6–12 complete the SPIRIT Survey, which is an adaptation of the Missouri Student Survey and measures substance use, family management, stress management, decision making, self-esteem, perceived risk of using substances, frequency of anti-social behavior, and attitudes toward substance use. Additional data are collected on students in grades 4–12, including grades, disciplinary incidents, school attendance, race, age, and gender. The third year report presented data from 1,287 students.

FY 2007 (Intended Use)

The estimates of substance abuse treatment need in Missouri that were revised by the Division of Alcohol and Drug Abuse (ADA) in FY 2006 will be updated in FY 2007 based on new sub-state estimates of alcohol and illicit drug dependence and abuse developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. The SAMHSA estimates are derived from multi-year Missouri samples from the National Survey on Drug Use and Health (NSDUH). The updated prevalence estimates will be used by ADA in developing annual legislative reference data and the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse FY 2009 budget request. The data will also be used to estimate public sector treatment needs and public sector treatment penetration rates. The updated prevalence estimates will be provided and summarized in the 13th edition of the *Status Report on Missouri's Alcohol and Drug Abuse Problems* scheduled for publication in April 2007.

The Governor's Substance Abuse Prevention Initiative Advisory Committee is developing criteria for allocating funds for program implementation under the Strategic Prevention Framework State Incentive Grant (SPF SIG). Sub-recipients funded through the SPF SIG will be required to assess needs, resources, and readiness at the community level as part of their planning process. Prevention data on local intervening variables related to the state's priority issue of risky drinking among young people ages 12-25 will be identified, collected, and monitored throughout the SPF SIG project. National Outcome Measures specific to local prevention projects will be collected at the community level. Data indicators for geographic and demographic subpopulations will be included in local and state assessments of prevention need. ADA will continue to plan for the biennial Missouri Student Survey which will next be conducted in the spring of 2008. The survey will be available online to all of Missouri's school districts. ADA will continue to collect data on the progress of students participating in the School-based Prevention and Intervention (SPIRIT) initiative.

Missouri

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) has continued the policy ensuring no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs. ADA's contracts with treatment providers state: "The contractor agrees and understands that payments received under the contract SHALL NOT be expended in the following manner: to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection."

Contract providers are required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy has been ensured through contract monitoring in the following ways: three year Certification Survey's, Annual Safety and Basic Assurance Reviews and periodic site visits by the Regional Administrators and Area Treatment Coordinators.

FY 2006 (Progress)

The Division of Alcohol and Drug Abuse (ADA) has continued the policy ensuring that no program funded through the Block Grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Contract providers are required to adhere to ADA policy prohibiting the distribution of hypodermic needles for the injection of illegal drugs and distribution of bleach for the purpose of cleaning needles for such injection. The policy has been ensured through contract monitoring in the following ways: three year Certification Survey's, Annual Safety and Basic Assurance Reviews and periodic site visits by the Regional Administrators and Area Treatment Coordinators.

FY 2007 Intended Use

The Division of Alcohol and Drug Abuse (ADA) will continue to facilitate independent peer reviews to encourage and assess the quality, appropriateness and efficacy of the substance abuse treatment being provided. Peer reviews will be scheduled in each region of the state annually. Area Treatment Coordinators will be responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report will be distributed to the District Administrator, agency being reviewed and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator will review the report with the appropriate agency staff.

Missouri

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007 (Intended Use):

FY 2004 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness and efficacy of substance abuse treatment and services provided. Seven independent peer reviews were conducted in FY 2004. The contracts for treatment providers require that they make staff available to perform peer reviews of other agencies in the state.

Peer Review Contract Language:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

FY 2006 (Progress)

The Division of Alcohol and Drug Abuse (ADA) facilitated seven peer reviews for FY 2006. Reviews were conducted in each region of the state and generally involve providers from different regions. The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report are distributed to the District Administrator, agency being reviewed and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator review the report with the appropriate agency staff.

FY 2007 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to facilitate independent peer reviews to encourage and assess the quality, appropriateness and efficacy of the substance abuse treatment being provided. Peer reviews will be scheduled in each region of the state annually. Area Treatment Coordinators will be responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report will be distributed to the District Administrator, agency being reviewed and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator will review the report with the appropriate agency staff.

Missouri

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))
For the fiscal year two years prior (FY 2005) to the fiscal year for which the State is applying for funds:

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2005 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of procedures may include, but not be limited to:

- the role of the single State authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of activities may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

Attachment H

The Division of Alcohol and Drug Abuse (ADA) utilizes independent peer review as one of several methods to encourage and assess the quality, appropriateness and efficacy of substance abuse treatment services provided. ADA has been contractually requiring all treatment providers to participate in independent peer review since July, 1993. Contracted providers have been cooperating with this requirement each year since that time. Six reviews were conducted in FY 2002. Seven reviews were conducted each fiscal year in FY 2003, FY2004, FY2005, and FY2006.

The contract between ADA and the treatment provider includes language which requires each provider to participate in the peer review process. The contract states:

1. The contractor shall make staff available for the Peer Review process in accordance with the following conditions:

    - A maximum of five (5) days of staff time may be required during each contract period;

    - The contractor and the Department will mutually agree upon the date, time, and location of the peer reviews;

    - Travel expenses will be reimbursed per the Department regulations;

    - Peer reviewers will be accompanied by staff from the Department and will not be expected to work alone; and

    - The peer review process will focus on the quality, appropriateness, and efficacy of treatment services provided as well as other areas, as defined by the Department.

2. Peer review staff shall submit a written report of their findings and recommendations, to the District Administrator of the district in which the peer review was conducted, within ten (10) working days of completion of the review.

The peer review process is effective in providing valuable feedback to ADA and treatment providers. Area Treatment Coordinators are responsible for initiating the peer review process. A reporting system is in place to encapsulate information collected through the review process. Copies of the report are distributed to the District Administrator, agency being reviewed and ADA's treatment and fiscal staff. The District Administrator and Area Treatment Coordinator review the report with the appropriate agency staff.

The agency being reviewed cooperates by providing access to client records, staff and policy and procedures documents. The reviewer utilizes this information to establish the agency's compliance with certification standards, Best Practices and efficacy in operations. The reviewer has an opportunity to learn from another program's operations. The information is also useful to the ADA's treatment specialists and other staff that provide monitoring and technical assistance to the agencies statewide. In addition to contract compliance, the role of the Area Treatment Coordinator is to conduct safety and basic assurances monitoring, provide technical assistance, and/or arrange for technical assistance visits. Some of the feedback provided through the peer review process includes suggestions regarding treatment planning, documentation, cultural diversity, and agency systems improvement.

Federal Confidentiality Regulations are observed throughout the individual peer review process. All members of the peer review team are knowledgeable of, and agree to comply with, federal confidentiality regulations in carrying out their assigned duties.

Missouri

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. part 2).

FY 2004 (Compliance):

FY 2006 (Progress):

FY 2007(Intended Use):

FY 2004 (Compliance)

The Division of Alcohol and Drug Abuse (ADA) has complied with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and, as of April 2003, the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complied with these federal regulations in the processing, storage and appropriate release of consumer information. ADA also required contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance have been provided to contracted program staff to ensure compliance with the federal regulations. ADA monitors the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurance Reviews and periodic site visits by Regional Administrators and Area Treatment Coordinators.

FY 2006 (Progress)

The Division of Alcohol and Drug Abuse (ADA) continued to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA complies with these federal regulations in the processing, storage and appropriate release of consumer information. ADA also requires contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. All new ADA employees received orientation and training to division policy and the above sited confidentiality laws. Training and technical assistance continue to be provided to contracted program staff to ensure compliance with the federal regulations. The Missouri Medicaid Provider Manual for CSTAR treatment providers was revised to reflect the required compliance with confidentiality laws. ADA continues to monitor the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurance Reviews and periodic site visits by Regional Administrators and Area Treatment Coordinators.

FY 2007 (Intended Use)

The Division of Alcohol and Drug Abuse (ADA) will continue to comply with the Department of Health and Human Services Final Rule 42 C.F.R. part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and the Health Insurance Portability and Accountability Act [HIPAA] of 1996. ADA will continue to require contracted service providers and business associates to appropriately comply with these regulations through incorporation of the requirements into certification standards and provider contracts. Training and technical assistance will continue to be provided to contracted program staff to ensure compliance with the federal confidentiality regulations. ADA will continue to monitor the compliance of providers with the above confidentiality regulations through Certification Surveys, Safety and Basic Assurance Reviews and periodic site visits by Regional Administrators and Area Treatment Coordinators.

Missouri

Goal #17: Charitable Choice

GOAL #17. An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(c)(4) and 54.8(b), Charitable Choice Provisions and Regulations).

FY 2004 (Compliance): Not Applicable

FY 2006 (Progress):

FY 2007 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

FY 2004 (Compliance)

Not Applicable

FY 2006 (Progress)

Missouri Code of State Regulations requires that creed not be used as criteria upon which to deny an individual admission to services. The right of consumers to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances.)

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide block grant treatment services requires that those agencies comply with Block Grant Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

Contract providers were required to follow the above procedures. There are 50 contracted treatment providers in Missouri of which two have identified themselves as being faith based organizations. The number of recovery support providers contracting with ADA has increased dramatically over the past year. Currently there are 103 recovery support providers of which 89 have identified themselves as faith-based organizations. Programs currently certified by the Division of Alcohol and Drug Abuse to provide clinical substance abuse treatment services are not eligible to be recovery supports providers. Faith-based organizations desiring to provide recovery support services must be credentialed by the Department of Mental Health, Division of Alcohol and Drug Abuse and the Committed Caring Faith Communities, an independent statewide 501(c)(3) interfaith corporation. Nontraditional service providers desiring to provide recovery support services through ATR must be credentialed by the Department of Mental Health, Division of Alcohol and Drug Abuse.

Consumers are informed of their right to Charitable Choice and provide written acknowledgement of their choices. Treatment and recovery support decisions are made with the participation of and in collaboration with consumers and treatment providers. Consumers are provided with recovery support vouchers that allow for charitable choice and authorize services as a result of consumer-requested referrals to faith-based and non-traditional organizations. There were no such consumer-requested referrals from contracted treatment providers. There were six consumers from “Saved to Serve”, a faith-based recovery support

provider who made chartable choice decisions and were referred to other recovery support providers.

Guidelines, training and technical assistance have been made accessible to providers. An application process to become an Access to Recovery provider was implemented which includes certification from the Addictions Academy (a 32-hour training program that integrates charitable choice). Personnel designated specifically for this program perform oversight and audits of programs and services.

FY 2007 (Intended Use)

Missouri Code of State Regulations will continue to require that the right of an individual to not be denied admission or to receive services shall not be limited based on creed. The right of an individual to attend or not attend religious services shall not be limited (9 CSR 10-7.020 Rights, Responsibilities, and Grievances.)

The contract between the Division of Alcohol and Drug Abuse (ADA) and religious organizations that provide block grant treatment services will continue to require those agencies to comply with the Charitable Choice requirements by following the procedures listed below:

1. Declare themselves as religious organizations;

2. Provide notice to program beneficiaries, utilizing the model language in the final regulations;

3. Maintain a record of requests for alternative services based upon religious objection or preference;

4. Provide referrals to alternative, essentially equivalent, secular services in response to consumer requests;

5. Report requests and referrals to ADA on an annual basis.

ADA will continue to develop resources that involves traditional, non-traditional and faith based organizations interested in providing recovery support services under the Access to Recovery (ATR) project. Recovery support providers will continue to allow charitable choice in substance use treatment services to consumers. Continuing training, certification and monitoring will ensure the consumers have charitable choice and quality services. Additional training opportunities will be provided during the next Addictions Academy and ADA's Spring Training Institute.

All data collected to meet reporting requirements and conduct longitudinal outcome evaluation will be incorporated into the Customer Information Management, Outcomes, and Reporting (CIMOR) system. All service providers will be required to collect and enter this information into the CIMOR system. The Missouri Institute of Mental Health will serve as the contractor to collect data for the ATR project

State:
Missouri

Attachment I

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Attachment I - Charitable Choice

For the fiscal year prior (FY 2006) to the fiscal year for which the State is applying for funds provide a description of the State’s procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries - Check all that apply:

- ☒ Use model notice provided in final regulations.
- ☐ Use notice developed by State (attached copy).
- ☒ State has disseminated notice to religious organizations that are providers.
- ☒ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☒ State has incorporated this requirement into existing referral system(s).
- ☒ SAMHSA’s Treatment Facility Locator is used to help identify providers.
- ☒ Other networks and information systems are used to help identify providers.
- ☒ State maintains record of referrals made by religious organizations that are providers.
- ☒ 6 Enter total number of referrals necessitated by religious objection to other substance abuse providers ('alternative providers'), as define above, made in previous fiscal year. Provide total ONLY; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Missouri was awarded $22.8 million over three years to implement a statewide voucher system for adults that affords genuine, free and independent choice among an increased number of qualified service providers; provides recovery support services through traditional, non-traditional and faith-based organizations; expands the existing managed care system for proper control and monitoring; and measures outcomes in seven critical domains. Faith organizations and other nontraditional providers interested in providing recovery support services under the Access to Recovery project are required to have a minimum of two staff or volunteers complete the Addictions Academy. Charitable Choice requirements are integrated into this training.

Attachment I Footnotes
States have the option to postpone specific reporting on referrals until the submission of the FY 2006 uniform application (October 1, 2005).

State:
Missouri

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))

- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))

- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))

- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))

- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Attachment J Footnotes
Missouri is not requesting any waivers.

Missouri

Attachment J: Waivers

Attachment J: Waivers

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Missouri

Description of Calculations

Description of Calculations

In a brief narrative, provide a description of the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

Description of Calculations

TB SERVICES

The Division of Alcohol and Drug Abuse (ADA) works in cooperation with the Missouri Department of Corrections (DOC), Missouri Department of Health (DMH) and Senior Services (DHSS), and the Missouri Department of Social Services (DSS), Division of Medical Services to collect the information required to report the statewide non-federal cost of Tuberculosis Services provided citizens of Missouri, as well as to the substance abusers in treatment in Missouri. The statewide expenditures for Tuberculosis Services to substance abusers in treatment have been calculated with the following methodology.

The DOC provides aggregated costs of TB services to inmates in correctional facilities, and associated costs to those inmates in institutional substance abuse treatment programs.

The DHSS provides aggregated costs of the number of clients treated for TB by local health departments. In addition, non-federal cost of the TB tests performed at local health departments is computed for clients referred from ADA funded treatment programs.

The DSS provides statewide expenditures for claims with TB diagnosis codes per the Missouri Medicaid Management Information System. The State Medicaid expenditures for TB treatment provided by ADA funded programs per the Department of Mental Health Purchase of Service (POS) system are a subset of the information received from Medical Services and represent the percent of expenditures that were spent on substance abusers in treatment.

The final component of the TB cost determination is from the DMH Purchase of Service (POS) system which captures services delivered to clients by service code. The payments for these non-Medicaid TB services were summed and segregated by funding source (Non-Federal or State Funds) per the POS data system.

PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

ADA used the following method to calculate the amounts for the base and subsequent years for services to pregnant women and women with dependent children. The DMH POS system captures services delivered to clients by service code. For the base year 1992, all payments for services to women at programs meeting the requirements of Section 1922© and Section 96.124 (e) were summed and segregated by funding source (Federal Block Grant and Non-Federal or State Funds). The total expenditures on these qualified programs

were $9,553,405 for FFY2005 and projected to be $9,014,401 for FFY2006. These amounts are greater than the required base expenditures of $7,728,020.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State:
Missouri

Dates of State Expenditure Period:
From 7/1/2004 to 6/30/2005

Activity	A. SAPT Block Grant FY 2004 Award (Spent)	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$19,989,944	$23,313,287	$3,253,982	$24,699,454	$	$
2. Primary Prevention	$5,286,923		$2,291,257	$773,022	$	$
3. Tuberculosis Services	$20,924	$44,277	$	$25,975	$	$
4. HIV Early Intervention Services	$	$86,090	$	$918,863	$	$
5. Administration (excluding program/provider level)	$1,086,621		$83,262	$1,598,524	$	$
6. Column Total	$26,384,412	$23,443,654	$5,628,501	$28,015,838	$	$

Form 4a

Primary Prevention Expenditures Checklist

State:
Missouri

	Block Grant FY 2004	Other Federal	State	Local	Other
Information Dissemination	**$793,788**	**$543,897**	**$7,697**	**$**	**$**
Education	**$2,012,295**	**$471,805**	**$393,802**	**$**	**$**
Alternatives	**$195,193**	**$468,750**	**$199**	**$**	**$**
Problem Identification & Referral	**$7,287**	**$**	**$**	**$**	**$**
Community-Based Process	**$1,020,790**	**$112,200**	**$15,640**	**$**	**$**
Environmental	**$610,842**	**$464,283**	**$27,250**	**$**	**$**
Other	**$343,729**	**$230,322**	**$22,390**	**$**	**$**
Section 1926 - Tobacco	**$302,999**	**$**	**$306,044**	**$**	**$**
TOTAL	**$5,286,923**	**$2,291,257**	**$773,022**	**$**	**$**

Form 4a Footnotes
Section 1926 - Tobacco (State) sources are General Revenue and Healthy Family Trust Funds (tobacco settlement funds).

Sources "Other Federal":
- Enforcing Underage Drinking Laws (WUDL) Block Grant
- Community Trials Initiative (EUDL Discrtionary grant)
- Safe & Drug Free Schools & Communities
- State Incentive Planning Grant
- Strategic Framework Prevention State Incentive Grant

Form 4b

Resource Development Expenditure Checklist

State:
Missouri

Did your State fund resource development activities from the FY 2004 block grant?

☒ Yes ☐ No

	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	**$**	**$289,802**	**$**	**$289,802**
Quality Assurance	**$160,645**	**$**	**$**	**$160,645**
Training (post-employment)	**$18,587**	**$**	**$**	**$18,587**
Education (pre-employment)	**$**	**$**	**$**	**$**
Program Development	**$32,000**	**$172,143**	**$**	**$204,143**
Research and Evaluation	**$30,000**	**$188,393**	**$**	**$218,393**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$241,232**	**$650,338**	**$**	**$891,570**

Expenditures on Resource Development Activities are:

☒ **Actual** ☐ **Estimated**

Form 6 Footnotes
Entities without I-SATS IDs are prevention programs. Per Synectics instructions Missouri has not assigned I-SATS IDs to non-treatment programs.

PROVIDER ADDRESS TABLE

State:
Missouri

Provider ID	Description	Provider Address
152	St Louis Area Nation Council on ADA	8790 Manchester Road, St. Louis, MO, 63144, 314-962-3456,
171	National Council on ADA GR KC	633 East 63rd Street, Kansas City, MO, 64110, 816-361-5900,
209	Safety Council of the Ozarks	1111 South Glenstone, Springfield, MO, 65804, 417-869-2121,
211	Affiliated Court Servies	800 North Providence, Ste 104, Columbia, MO, 65201, 573-499-3784,
216	CAAREC	326 Cherry Street, Chillicothe, MO, 64601, 660-646-1652,
217	Central States MH Cons	3217 South Owens Road, Independence, MO, 64057, 816-224-4417,
219	County Court Services	PO Box 32267, Kansas City, MO, 64171, 816-474-2121,
220	Rasse, David R. and Assoc.	78 West Arrow Street, PO Box 38, Marshall, MO, 65340, 660-886-3373,
227	Safety Council of Gr Stl	1015 Locust Street, Ste 902, St Louis, MO, 63101, 314-621-9200,
231	Traffic Safety Awareness Prog	PO Box 575, Linn Creek, MO, 65052, 573-346-3829,
252	Accredited Traffic Offenders	1515 Mqalone, Sikeston, MO, 63801, 573-471-7710,
264	Door To Hope	1714 Camp Clark Hill, Galena, MO, 65656-0015, 417-357-6263,
267	MO Association for Community Task Force	428 East Capitol Avenue, Second Floor, Jefferson City, MO, 65101, 573-635-6669,
274	Alcohol Drug Consultants	1736 East Sunshine, Ste 214, Springfield, MO, 65804, 417-848-4565,
277	Heartland Alternative Sevc Prog	414 Poplar Street Ste 1, Poplar Bluff, MO, 63901, 573-686-5488,
282	St Joseph Safety & Health Council	118 South Fifith Street (lower level), St. Joseph, MO, 64501-2130, 816-233-3330,
287	Deaf Hope	PO Box 14441, Shawnee Mission, KS, 66215, 913-281-4875,
288	South Central Missouri Citizens	1015 Lanton Road, West Plains, MO, 65775, 417-256-2570,
297	About Face Community Counseling	6301 Rockhill Road, Kansas City, 64131, 816-444-6200,
313	ADAPT, LLC	616 East 63rd Street, Kansas City, MO, 64110, 816-523-4000,

Provider ID	Description	Provider Address
401	Community Housing Network	2600 East 12th STreet, Kansas City, MO, 64127, 816-482-5744,
402	Covington Burling	1201 Pennsylvania Ave, NW, Washington, DC, 20044, 202-662-5410,
403	Oxford House, Inc.	1010 Wayne Avenue, Ste 400, Silver Spring, MD, 20910,
404	University of MO KC Inst for Human Development	2220 Holmes, Kansas City, KC, 64108,
405	University of MO - Columbia	Office of Spinsored Programs 310 Jessie, Columbia, MO, 65211, 573-882-7580,
406	Big Brothers/Big Sisters of Eastern Mo	4625 Lindell Blvd, St Louis, MO, 63108,
407	Community Movement - Move Up	3330 Troost Avenue, Kansas City, MO, 64109, 816-842-8515,
408	Community Partnership of Ozarks	330 N. Jefferson, Springfield, MO, 65806, 417-863-7700,
409	County of Greene Prosecuting Att	1010 Boonville, Springfield, MO, 658802,
410	Dept of Elementary/Secondary Ed	PO Box 480, Jefferson City, MO, 65102,
411	Discovering Options	909 Purdue Avenue, St Louis, MO, 63130, 314-721-8116,
412	Friends with a Better Plan	5622 Delmar Suite 102E, St Louis, MO, 63112, 314-361-2371,
413	L.E.A.D. Institute, The	311 Bernadette Drive, Ste C, Columbia, MO, 65203, 573-817-2400,
414	Lincoln University	Business & Finance 306 Young Hall, Jefferson City, MO, 65102, 573-681-5058,
415	Mississippi County 33rd Circuit Ct	PO Box 369, Charleston, MO, 63834, 573-683-2146,
416	Mo Alliance of Boys/Girls Club	6301 Rockhill Road, Ste 303, Springfield, MO, 64131, 816-361-3600,
417	Prevention Consultants of Mo	104 East 7th Street, Rolla, MO, 65401, 573-368-4755,
418	Southeast Mo State University	One University Plaza, Cape Girardeau, MO, 63701, 573-651-2196,
419	St Louis Department of Health	634 North Grand, St Louis, MO, 63178, 314-658-1140,
420	United Way of the Ozarks	320 N. Jefferson, Springfield, MO, 65806-1109, 417-863-7700,

Provider ID	Description	Provider Address
421	University of Oklahoma	Office of Proj & Compl Ass. 660 Parrington Oval 324, Norman, OK, 73019, 918-660-3700,
422	Office of State Court Administrators	2212 Industrial, PO Bopx 104480, Jefferson City, MO, 65102, 573-751-4377,
423	Save, Inc.	PO Box 45301, Kansas City, MO, 64171, 816-531-8340,
8	Central Office	1706 East Elm Street, Jefferson City, MO, 65101, 573-751-4942,

Prevention Strategy Report

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Mentors [15]	3
	Preschool ATOD prevention programs [16]	2
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	4
	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Pregnant Women/Teens [2]	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Drop-Outs [3]	Clearinghouse/information resources centers [1]	3
	Resources directories [2]	16
	Media campaigns [3]	3
	Information lines/Hot lines [8]	1
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	0
	Drug free dances and parties [21]	2
	Community service activities [24]	12
	Recreation activities [26]	5
	Student Assistance Programs [32]	12
	Community team-building [44]	12
	Accessing services and funding [45]	12
Violent and Delinquent Behavior [4]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	2
	Community service activities [24]	12
	Recreation activities [26]	5

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Violent and Delinquent Behavior [4]	Driving while under the influence/driving while intoxicated education programs [33]	12
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Accessing services and funding [45]	12
Mental Health Problems [5]	Clearinghouse/information resources centers [1]	4
	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	12
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Economically Disadvantaged [6]	Resources directories [2]	16

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Economically Disadvantaged [6]	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	2
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Systematic planning [42]	12
	Community team-building [44]	12
	Accessing services and funding [45]	12
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	12
Physically Disabled [7]	Clearinghouse/information resources centers [1]	3
	Media campaigns [3]	0
	Brochures [4]	2
	Speaking engagements [6]	2
	Information lines/Hot lines [8]	1

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Physically Disabled [7]	Preschool ATOD prevention programs [16]	2
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
Abuse Victims [8]	Clearinghouse/information resources centers [1]	3
	Media campaigns [3]	2
	Brochures [4]	22
	Speaking engagements [6]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Parenting and family management [11]	6
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	3
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Multi-agency coordination and collaboration/coalition [43]	12
	Community team-building [44]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	12
Already Using Substances [9]	Resources directories [2]	16
	Media campaigns [3]	2

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Already Using Substances [9]	Brochures [4]	22
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	22
	Information lines/Hot lines [8]	1
	Parenting and family management [11]	5
	Ongoing classroom and/or small group sessions [12]	9
	Peer leader/helper programs [13]	2
	Education programs for youth groups [14]	9
	Mentors [15]	5
	Drug free dances and parties [21]	3
	Youth/adult leadership activities [22]	5
	Community service activities [24]	2
	Recreation activities [26]	5
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	22
	Community team-building [44]	12
	Accessing services and funding [45]	12
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	16
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	12
Homeless and/or Run away Youth [10]	Clearinghouse/information resources centers [1]	3
	Resources directories [2]	16
	Media campaigns [3]	0
	Brochures [4]	22
	Radio and TV public service announcements [5]	1

Form 6a: Risk - Strategies (...continued)

State:
Missouri

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Homeless and/or Run away Youth [10]	Information lines/Hot lines [8]	1

TREATMENT UTILIZATION MATRIX

State:
Missouri

Dates of State Expenditure Period:
From 7/1/2004 to 6/30/2005 (Same as Form 1)

			Costs Per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons Served**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24 hour Care)					
1. Hospital Inpatient			**$.00**	**$.00**	**$.00**
2. Free-standing Residential	**8,438**	**6,322**	**$259.00**	**$205.00**	**$141.00**
Rehabilitation / Residential					
3. Hospital Inpatient			**$.00**	**$.00**	**$.00**
4. Short-term (up to 30 days)	**7,448**	**8,334**	**$1,560.00**	**$1,622.00**	**$328.00**
5. Long-term (over to 30 days)	**505**	**501**	**$2,266.00**	**$2,200.00**	**$589.00**
Ambulatory (Outpatient)					
6. Outpatient	**19,359**	**20,466**	**$285.00**	**$133.00**	**$83.00**
7. Intensive Outpatient	**22,807**	**17,513**	**$2,106.00**	**$1,216.00**	**$314.00**
8. Detoxification			**$.00**	**$.00**	**$.00**
Methadone	**862**	**1,219**	**$1,469.00**	**$1,311.00**	**$71.00**

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

Form 7b

Number Of Persons Served (Unduplicated Count) For Alcohol And Other Drug Use In State-Funded Services By Age, Sex, And Race/Ethnicity

State:
Missouri

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

AGE GROUP	A. TOTAL	B. White		C. Black		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	8,904	4,309	2,301	1,319	656	5	1	9	5	19	20	56	43	103	58	5,700	3,011	120	73
2. 18-24	12,845	7,123	2,911	1,731	731	14	3	13	7	34	27	25	11	162	53	8,955	3,666	147	77
3. 25-44	23,037	10,954	5,490	4,036	1,906	31	11	18	8	65	48	16	8	357	89	15,154	7,433	323	127
4. 45-64	4,475	2,432	846	859	230	3		4	1	16	5	1		66	12	3,309	1,073	72	21
5. 65 and over	196	133	19	39	3									2		170	22	4	
6. Total	49,457	24,951	11,567	7,984	3,526	53	15	44	21	134	100	98	62	690	212	33,288	15,205	666	298
7. Pregnant Women	462		325		127						2		1		7		450		12

Did the State base the values reported on Form 7A and 7B from a client-based system(s) with unique client identifiers?

☒ **Yes** ☐ **No**

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period: 47,716

Form 7b Footnotes
The number served in FY 2004 as reported on 7b in the 2006 SAPT application was underreported at 39,465. The table used to pull the data for that submission did not contain demographic information on all clients served. However this year's 7b correctly reflects 47,716 were served in the "period prior to the 12 month reporting period" or FY 2004.

State:
Missouri

SSA (MOE Table I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2004) + B2(2005) / 2 (C)
SFY 2004 (1)	$36,595,848	
SFY 2005 (2)	$37,041,952	$36,818,900
SFY 2006 (3)	$38,930,686	

Are the expenditure amounts reported in Columns B "actual" expenditures for the State fiscal years involved?

FY 2004 ☒ **Yes** ☐ **No**

FY 2005 ☒ **Yes** ☐ **No**

FY 2006 ☒ **Yes** ☐ **No**

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA(mm/dd/yyyy):

The MOE for State fiscal year(SFY) 2006 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

☐ **Yes** ☒ **No** **If yes, specify the amount** $0

Did the State include these funds in previous year MOE calculations? ☐ **Yes** ☒ **No**

When did the State submit a request to the SAMHSA Administration to exclude these funds from the MOE calculations(Date)?

SSA (MOE Table I) Footnotes
Updated SYF 06 expenditures on 8-29-07 to include funding inadvertently left out.

TB (MOE Table II)

State:
Missouri

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) (C)	Average of Columns C1 and C2 C1 + C2 / 2 MOE BASE (D)
SFY 1991 (1)	$421,670	.06%	$253	
SFY 1992 (2)	$455,117	.5%	$2,276	$1,264

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B)
SFY 2006 (3)	$643,507	2.98%	$19,177

HIV (MOE Table III)

State:
Missouri

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)	Average of Columns A1 and A2 A1 + A2 / 2 MOE BASE (B)
SFY1993 (1)	$298,242	
SFY1994 (2)	$304,625	$301,434

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2006 (3)	$0

*** Provided to substance abusers at the site at which they receive substance abuse treatment**

HIV (MOE Table III) Footnotes
Missouri is not a designated state.

Womens (MOE TABLE IV)

State:
Missouri

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

PERIOD	Total Women's BASE (A)	Total Expenditures (B)
1994	$7,728,020	
2004		$9,902,206
2005		$9,553,405
2006		$10,686,147

Enter the amount the State plans to expend in FY 2007 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $9,400,500

Womens (MOE TABLE IV) Footnotes
Edited the 2006 expenditures on 8-29-07 to reflect the actual expenditures for that period.

State:
Missouri

FY 2004 SAPT BLOCK GRANT

Your annual SAPT Block Grant Award for FY 2004 is reflected on Line 8 of the Notice of Block Grant Award

$26,384,412

Missouri

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29 requires the State to submit a Statewide assessment of need for both treatment and prevention.
- 42 U.S.C. 300x-51 requires the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of up to three pages, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. If there is a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, describe its composition and its role in needs assessment, planning, and evaluation processes.

In a narrative of up to two pages, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2007 application for SAPT Block Grant funds.

Substate Area Planning

The Missouri Department of Mental Health has five planning regions that are used by its Division of Alcohol and Drug Abuse (ADA) and Division of Comprehensive Psychiatric Services (CPS). The ADA planning regions are further divided into Service Areas consisting of clusters of counties. The largest metropolitan Service Areas comprise one or two counties while some of the rural Service Areas cover up to nine counties. In June 2000, the ADA completed a planning process that culminated in the goal of providing a full array of substance abuse services in each of ADA's 20 Service Areas. Since then, decisions regarding the placement of new or expanded services have generally been based on prioritizing the treatment or prevention needs of each Service Area and then identifying the un-served or under-served areas with the greatest unmet need. To support planning and allocation at this geographic level, needs assessment data is captured by Service Area whenever possible.

For several years, the State Treatment Needs Assessment Program (STNAP) has provided estimates of substance abuse treatment need. The STNAP-I household report was finalized in 1997 and the estimates were supplemented in 1999 for non-household populations. Based on a broader household survey and a jail inmate study completed for the STNAP-II project, updated treatment needs estimates were compiled for the report *Integrating Population Estimates of Substance Abuse Treatment Need in Missouri: 2003 Update*. The new study provided estimates for adolescents as well as adults and for each Service Area.

A recent use of the STNAP data was an analysis for primary recovery treatment expansion under the Access to Recovery CSAT grant. The focus was to identify the Service Areas of the state most in need of new or additional services for adult women, based on rankings of criteria and changes in rankings from 2000. Data from the STNAP-II were used in formulating two of the five criteria -- the number of women needing treatment and the percent needing treatment who are pregnant. A third criterion was treatment penetration rates of ADA's adult female target population. Rather than defining target population using the STNAP-II estimates of the number who would seek treatment, ADA used data from the *2003 National Survey of Substance Abuse Treatment Services (N-SSATS),* which found that 80.8 percent of Missouri treatment clients received services in non-profit programs that utilize state and federal funds. That percentage was applied to the STNAP-II treatment needs estimates to determine the number who would need to access publicly supported treatment programs administered by ADA. The other two criteria used for ranking Service Area need for women's services dealt with Medicaid eligible births and availability of Medicaid eligible services.

Prevention planning and identification of highest need are ongoing processes. Data collection has evolved from solely qualitative community-based information to more comprehensive methods. The process has expanded the CSAP Prevention Needs Assessment Studies and has incorporated new data from other resources. Two of the Prevention Needs Assessment Studies, the

Missouri Student Survey and the Social Indicator study, have been utilized at the local level by coalitions for identifying needs and requesting funding for local level mini-grants, other federal and private sources of funding for strategies and programming. The studies were also part of the identification process for the five pilot sites of the School-based Prevention and Intervention Initiative (SPIRIT). Information for risk and prevalence data is captured through both qualitative and quantitative methods. Additionally, as a pilot state for CSAP's MIS project, ADA's service providers are required to input service process information into the Minimum Data Set (MDS-3) server. The MDS-3 project collects service type, target audience, aggregate demographics of participants, and risk factors. Since the initial replication of the Missouri Student Survey in 2002, subsequent prevention initiatives have used a variety of methods and different levels of substate data collection. ADA initiatives and programs have provided the following information: specific K-12 school data and research-based program monitoring of the School-based Prevention and Intervention Initiative (SPIRIT); training needs of the prevention workforce, the Prevention Works: the Next Step research project (Pentz and Hawkins); localized underage drinking information from the OJJDP EUDL discretionary awards; and binge drinking rates among college students from the CORE survey.

The one-year CSAP State Incentive Planning Grant and the five-year Strategic Prevention Framework State Incentive Grant (SPF SIG) are making a significant contribution to planning through the formation of the Governor's Substance Abuse Prevention Initiative Advisory Committee. Building on the work and information from the CSAP Prevention Needs Assessment Studies completed in the early part of the decade, the Advisory Committee and its workgroups have completed or are currently developing several projects. They conducted Hispanic and Asian focus groups in each of the state's planning regions, piloted the Tri-Ethnic Institute's Community Readiness Assessment, developed an inventory of prevention resources and activities, and prepared a prevention needs assessment report. The Prevention Workforce Development Task Force was created in order to assess workforce activities and training needs and make recommendations regarding standardized training and multi-tier certification program. They have developed a Missouri Prevention Workforce Survey Report.

As a requirement of the SPF SIG, a State Epidemiology Workgroup (SEW) was established in April, 2005. Membership of the SEW consists primarily of data managers and researchers in government agencies that address substance abuse problems. These include the U.S. Drug Enforcement Administration, Missouri State Highway Patrol, Missouri Department of Health and Senior Services, Missouri Department of Corrections, Missouri Department of Social Services, Missouri Department of Mental Health, St. Louis Mental Health Board, and St. Louis Community Epidemiology Work Group. The SEW assembled and compared rates of Missouri and national substance abuse consumption and consequences data, including all data sets contained in the State Epidemiology Data System (SEDS). The SEW also used county-level Missouri data in a geographic information system to map the number of

occurrences--and population-based rates--of a variety of substance abuse consequences. These included alcohol and drug related traffic crashes, arrests, emergency room episodes, juvenile court referrals, out-of-home placements, and births compromised by maternal substance abuse. This data analysis, recommendations, and a comprehensive *SPF SIG Initial Needs Assessment* report developed by project staff at the Missouri Institute of Mental Health were presented to the Governor's Advisory Committee. The Advisory Committee considered several substance abuse problems identified as priority issues and adopted a state prevention plan that addresses risky drinking behavior, including underage and binge alcohol use in the 12-25 age group. The State Strategic Plan has been submitted to CSAP and approved for implementation. County-level data are not available in Missouri on underage and binge alcohol use, so the SEW will assist the prevention coalitions funded through the SPF SIG to develop data sources that can be used to measure the effectiveness of the funded projects in reducing rates of risky drinking. The SEW will also continue to monitor and compare national, state, and county data to support ongoing project planning, feedback to funded coalitions, and data-driven outcome evaluation.

Technological advances are also part of the evolving system. ADA strives to achieve more effective and efficient ways for risk, incidence, prevalence, and highest need identification. Such progress is evident with the improvements made in capturing student information. In 2000, the first Missouri Student Survey was administered to a random sample 12,600 students in 254 schools. In 2002, the survey was replicated using state specific lessons learned and a larger sample. The 2004 Student Survey was the first to be administered over the Internet using the SmartTrack application and was made available to all of Missouri's 524 school districts. Although not all districts were able to participate, approximately 60,000 students in grades 6–12 participated in the survey. The 2006 survey is expected to have 100,000 participants, making the Missouri Student Survey the largest of its type in the state.

Planning culminates with its integration into the state budgeting process. Treatment and prevention program performance and outcome measures are described and quantified in the annual budget requests of the Department of Mental Health and its divisions, including ADA. Measured performance is annually compared with projections, and new or revised decision items with plan components are developed to address emerging needs. During the processes of prioritizing and justifying these proposed programs and services, additional plan details such as client eligibility, treatment methods, program locations, and management issues are clarified and elaborated.

The advisory council network is an important link between the public and ADA. The Missouri Advisory Council on Alcohol and Drug Abuse, also known as the State Advisory Council (SAC), was established by statute and is an advisory body to ADA and the ADA director. The SAC is comprised of 25 members appointed by the director to three-year overlapping terms. Members must have professional, research, or personal interest in alcohol and drug abuse. At least one-half of the members must be consumers (non-providers) of services, and no more than one-fourth can be ADA treatment or prevention vendors. The SAC

collaborates with ADA in developing and administering a state plan on alcohol and drug abuse; promotes meetings and programs to reduce the debilitating effects of alcohol or drug abuse; and disseminates information on the prevention, evaluation, care, treatment, and rehabilitation for persons affected by alcohol or drug abuse. The SAC studies current technologies and recommends appropriate preparation, training, and distribution of manpower and its resources in the provision of services through private and public residential facilities, day programs, and other specialized services. The SAC recommends what specific methods, means, and procedures should be adopted to improve and upgrade the service delivery system, and participates in developing and disseminating criteria and standards to qualify facilities, programs, and services for state funding. Five Regional Advisory Councils (RACs), representing the five ADA planning regions, work with the SAC to identify and study local needs. The ADA Prevention Office provides the administrative and logistic support for the SAC and all of the RACs.

The SAC and RACs consult with ADA's district administrators, treatment coordinators, and prevention specialists. The treatment coordinators monitor the ADA-funded treatment programs and their utilization rates and refer prospective clients to programs which are the most appropriate, accessible, and available. The prevention specialists monitor ADA-funded prevention programs and provide consultation on appropriate strategies. The district administrators gather input from their staffs, the advisory council members, and other sources to develop a thorough understanding of the service gaps in their districts with regard to locations, types of services, and populations to be served. The ADA executives utilize data from the needs assessment models and consult with the district administrators on decisions involving program expansions and reallocations. Information from these multiple sources helps ensure that ADA expends its funds to provide services in communities and for populations with the greatest needs.

The Governor's Substance Abuse Prevention Initiative Advisory Committee provides an additional advisory body. With representation from state agencies impacted by substance abuse, other stakeholders, the SAC and RAC, and service providers, and with technical support from its subcommittees and the State Epidemiological Workgroup, the Advisory Committee will have an important role in making allocation recommendations to ADA.

Public Comment in Plan Development

The Missouri Advisory Council on Alcohol and Drug Abuse, commonly referred to as the State Advisory Council (SAC), and its network of five Regional Advisory Councils (RACs) constitutes the formal mechanism that ensures that Missouri citizens have an opportunity to participate in and express their views regarding the state's publicly funded substance abuse prevention and treatment system managed by the Missouri Division of Alcohol and Drug Abuse (ADA). The SAC's statutory mandate is to collaborate with ADA to disseminate public information about alcohol and drug abuse; review current social technologies and recommend improvements to substance abuse prevention and treatment programs based upon scientific evidence; recommend what should be changed--and how--to improve and update the substance abuse service delivery system; and participate in developing standards for prevention and treatment services.

The State Advisory Council has 25 members consisting of service providers, consumers (recipients of services or family members of recipients), and other interested citizens. The Council meets regularly and holds conference calls to receive updates from ADA staff and provide feedback on budget-related matters, legislative initiatives, strategic planning and performance measurement development, and other aspects of the service delivery system. The Council appoints ad hoc committees as needed to address priority issues and make recommendations to ADA. Each Regional Advisory Council (RAC) meets periodically and encourages discussion and analysis of local prevention and treatment issues, seeking input from individuals, agencies, and organizations involved in or impacted by substance abuse. Some RAC members also have roles as members of community-based prevention teams and coalitions, comprised of volunteers who provide leadership in substance abuse prevention, intervention, and policy development. The RAC chairpersons attend the regular meetings of the State Advisory Council and work with the SAC on various projects.

The content of the SAPT block grant application reflects recommendations generated through this citizen input. The compressed time frame for preparing the SAPT application precludes a full review by the advisory council network prior to its submission to the Center for Substance Abuse Treatment. To facilitate ongoing review, each application is posted to the ADA website at http://www.dmh.missouri.gov/ada/blockgrant.htm. ADA notifies the SAC and RAC members of the application submission, encourages them and their constituents to review it, and asks them to communicate their comments to ADA's central and district office staff for consideration in developing the next application. This process provides for ongoing access to the SAPT applications and feedback from the advisory network and the general public.

State:
Missouri

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use in deciding how to allocate FY 2007 Block Grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

3 Population levels, Specify formula:
2005 population estimates of service areas

3 Incidence and prevalence levels

4 Problem levels as estimated by alcohol/drug-related crime statistics

4 Problem levels as estimated by alcohol/drug-related health statistics

5 Problem levels as estimated by social indicator data

5 Problem levels as estimated by expert opinion

1 Resource levels as determined by (specific method)
maintenance of exixting services

2 Size of gaps between resources (as measured by)
number of clients served in last fiscal year

and needs (as estimated by)
Updated 2004 STNAP-II prevalence estimates based on the Missouri 2003/2004 NSDU

_ Other (specify):

Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Missouri	2004

1.	2.	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Northwest Region	1,396,212	85,748	2,945	3,049	1,281	25,562	956	7,895	12,646	27	11	3	3
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Central Region	759,887	84,927	8,203	1,651	474	25,995	2,377	5,392	4,532	187	7	1	2
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Eastern Region	2,060,937	206,268	15,097	4,445	1,874	63,728	4,931	10,308	13,522	1	10	3	3
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Southwest Region	853,689	60,803	2,153	1,905	128	20,312	972	6,770	6,142	16	11	1	2

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Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Missouri	2004

1.	2.	3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Southeast Region	688,807	61,254	2,670	1,524	291	19,270	1,224	4,816	4,931	2	7	1	2

Substate Planning Area	Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other: boating while intoxicated	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
State Total	5,759,532	499,000	31,069	12,573	4,048	154,866	10,460	35,181	41,773	233	10	2	3

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Treatment Needs by Age, Sex, and Race/Ethnicity

State:	Substate Planning Area [95]:
Missouri	State Total

AGE GROUP	A. TOTAL	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. UNKNOWN		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	51,000	30,475	14,793	0	0	0	0	0	0	0	0	0	0	3,778	1,954	0	0	0	0
2. 18 - 24	135,625	80,307	35,500	0	0	0	0	0	0	0	0	0	0	13,713	6,105	0	0	0	0
3. 25 - 44	207,231	121,191	53,904	0	0	0	0	0	0	0	0	0	0	22,288	9,848	0	0	0	0
4. 45 - 64	79,986	46,492	21,118	0	0	0	0	0	0	0	0	0	0	8,452	3,924	0	0	0	0
5. 65 and over	25,157	14,894	6,580	0	0	0	0	0	0	0	0	0	0	2,543	1,140	0	0	0	0
6. Total	498,999	293,359	131,895											50,774	22,971				

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State:
Missouri

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

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SOURCE OF FUNDS

(24 Month Projection)

Activity (see instructions for using Row 1)	A. FY 2007 SAPT Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$19,529,774	$46,626,574	$6,507,964	$49,398,908	$0	$0
2. Primary Prevention	$5,213,520		$4,582,514	$1,546,044	$0	$0
3. Tuberculosis Services	$20,924	$88,554	$0	$51,950	$0	$0
4. HIV Early Intervention Services	$0	$172,180	$0	$1,837,726	$0	$0
5. Administration (excluding program/provider level)	$1,303,380		$166,524	$3,197,048	$360,000	$0
6. Column Total	$26,067,598	$46,887,308	$11,257,002	$56,031,676	$360,000	$

Form 11 Footnotes
The source for the Local Funds in Column E for Administration is the Robert Woods Johnson Foundation.

Form 11a

Primary Prevention Planned Expenditures Checklist

State:
Missouri

	Block Grant FY 2007	Other Federal	State	Local	Other
Information Dissemination	**$782,767**	**$1,087,794**	**$15,394**	**$**	**$**
Education	**$1,984,357**	**$943,610**	**$787,604**	**$**	**$**
Alternatives	**$192,483**	**$537,500**	**$398**	**$**	**$**
Problem Identification & Referral	**$7,186**	**$**	**$**	**$**	**$**
Community-Based Process	**$1,006,617**	**$624,400**	**$31,280**	**$**	**$**
Environmental	**$602,361**	**$928,566**	**$54,500**	**$**	**$**
Other	**$338,957**	**$460,644**	**$44,780**	**$**	**$**
Section 1926 - Tobacco	**$298,792**	**$**	**$612,088**	**$**	**$**
TOTAL	**$5,213,520**	**$4,582,514**	**$1,546,044**	**$**	**$**

Form 11a Footnotes
State Sources
- General Revenue
- Healthy Family Trust (tobacco settlement funds)

Other Federal Sources
- Enforcing Underage Drinking Laws (EUDL)
- Safe and Drug Free Schools & Communities
- Strategic Framework Prevention State Incentive Grant

Form 11b

Planned Expenditures on Resource Development Activities

State:
Missouri

Does your State plan to fund resource development activities with FY 2007 funds?

☒ Yes ☐ No

	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	**$**	**$300,000**	**$**	**$300,000**
Quality Assurance	**$**	**$**	**$**	**$**
Training (post-employment)	**$50,000**	**$**	**$**	**$50,000**
Education (pre-employment)	**$**	**$**	**$**	**$**
Program Development	**$26,667**	**$183,239**	**$**	**$209,906**
Research and Evaluation	**$85,000**	**$450,000**	**$**	**$535,000**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$161,667**	**$933,239**	**$**	**$1,094,906**

Form 12

State:
Missouri

TREATMENT CAPACITY MATRIX

This form contains data covering a 24 month projection for the period during which your principal agency of the State is permitted to spend the FY 2007 block grand award.

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24 hour Care)		
1. Hospital Inpatient		
2. Free-standing Residential	**16,876**	**12,644**
Rehabilitation / Residential		
3. Hospital Inpatient		
4. Short-term (up to 30 days)	**14,896**	**16,668**
5. Long-term (over to 30 days)	**1,010**	**1,002**
Ambulatory (Outpatient)		
6. Outpatient	**38,718**	**40,932**
7. Intensive Outpatient	**45,614**	**35,026**
8. Detoxification		
Methadone	**1,724**	**2,438**

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Form 12 Footnotes
Generally the number of clients served will exceed the number of clients admitted for the same time period. The served group includes those additional clients who were admitted in a prior year but continue to be served during the year in question. There are some levels of care with high re-admission rates; in these instances the admission numbers may be greater than the number served.

State:
Missouri

Purchasing Services

Methods for Purchasing This item requires completing two checklists

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2007 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐	Competitive grants	Percent of Expense: %
☒	Competitive contracts	Percent of Expense: 99%
☐	Non-competitive grants	Percent of Expense: %
☒	Non-competitive contracts	Percent of Expense: 1%
☐	Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐	Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☐	According to county or regional priorities	Percent of Expense: %

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a States allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐	Line item program budget	Percent of Clients Served: % Percent of Expenditures: %
☐	Price per slot	Percent of Clients Served: % Percent of Expenditures: %
	Rate: Type of slot:	
	Rate: Type of slot:	
	Rate: Type of slot:	
☒	Price per unit of service	Percent of Clients Served: 100% Percent of Expenditures: 100%
	Unit: hour	Rate: 46.35
	Unit: hour	Rate: 9.26
	Unit: day	Rate: 5.21

☐ Per capita allocation (Formula):

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care:

Percent of Clients Served: %
Percent of Expenditures: %

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Program Performance Monitoring

☒ On-site inspections

(Frequency for treatment:) Annually

(Frequency for prevention:) Annually

☒ Activity Reports

(Frequency for treatment:) Monthly

(Frequency for prevention:) Monthly

☒ Management information System

☒ Patient/participant data reporting system

(Frequency for treatment:) Monthly

(Frequency for prevention:) Monthly

☒ Performance Contracts

☒ Cost reports

☒ Independent Peer Review

☒ Licensure standards - programs and facilities

(Frequency for treatment:) Every three years

(Frequency for prevention:) Every three years

☒ Licensure standards - personnel

(Frequency for treatment:) Every three years

(Frequency for prevention:) Every three years

☐ Other (Specify):

Missouri

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using up to three pages, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

How your State determined the numbers for the matrix

Column 1: Substate planning area

The Division of Alcohol and Drug Abuse (ADA) configures Missouri into five large planning regions, each consisting of clusters of counties referred to as Service Areas. Missouri's three largest cities anchor three of these regions. Kansas City is located in the Northwest Region, St. Louis is in the Eastern Region, and Springfield is in the Southwest Region. Columbia, the fifth largest city, is in the Central Region. Cape Girardeau is the largest city in the Southeast Region.

Column 2: Total population

The population of each sub-state region listed on Form 8 is based on the 2004 population estimates prepared by the U.S. Census Bureau and the Missouri Census Data Center.

Column 3: Total population in need

Prevalence estimates in column 3A reflect updates to the Missouri State Treatment Needs Assessment Program (STNAP-II) study. ADA prepared the updates in 2006 based on changes in the Missouri population that occurred between 2000 (the study's population base) and 2004. Adjustments were made for county-level population changes by age and gender. The updates also encompass Missouri estimates prepared by SAMHSA's Office of Applied Studies (OAS). The OAS estimates are derived from the Missouri samples from the National Survey on Drug Use and Health (NSDUH) for 2003 and 2004. Treatment need by age group is based on the OAS estimate of individuals with "alcohol or illicit drug dependence or abuse." The aggregate treatment need of 499,000 for Missouri is considered a valid approximation because it is very consistent with the STNAP-II estimate of 491,224 produced in the 2003 study. Total treatment need is disaggregated according to the OAS estimates for the age groups of 12-17, 18-25 (adjusted to 18-24), and 26 and older (adjusted for 25-44, 45-64, and 65 and over). Components of these estimates for ADA planning region, gender and race/ethnicity are based on the STNAP-II rates.

Column 3B provides updated estimates of the number who would seek treatment but are currently not receiving services. The updates utilize the treatment seeking rates for each Service Area from the STNAP-II study applied to the updated treatment need estimates for each Service Area aggregated to the planning regions. The updated total number who would seek treatment is 80,419. In FY 2005, ADA provided substance abuse treatment services to 49,350 Missouri residents whose county of residence (and therefore ADA planning region) are known. By subtracting the residents who accessed treatment services from the 80,419 who would seek treatment, an estimated 31,069 residents who would seek substance abuse treatment did not receive services in FY 2005. This unmet demand is reported by planning region in column 3B.

Column 4: Number of IVDUs in need

Prevalence estimates for Missouri's population in need of treatment for intravenous drug use was updated based on changes in the Missouri population that occurred between 2000 and 2004. The estimated 12,377 intravenous drug users

(IVDU) from the STNAP-II study was updated to 12,573 and all of these individuals need treatment. Although the STNAP-II study did not estimate the number of IVDU who would seek treatment, it did estimate that 50 percent of high-risk non-household adults would seek treatment. During the last two years ADA has actually provided services to more than 50 percent of the estimated IVDU in some of the planning regions, so a potential treatment seeking rate of 75 percent of prevalence was applied to the IVDU to yield an estimated 9,430 IVDU that would seek treatment. Subtracting the 5,382 IVDU who received treatment services in FY 2005 from the 9,430 who would seek services, an estimated 4,048 IVDU who would seek treatment did not receive services in FY 2005. This unmet demand is reported by planning region in column 4B.

Column 5: Number of women in need

The prevalence estimates totaling 154,866 women in column 5A are a subset of the updated treatment need estimates provided in column 3A and reflect changes in the female population of each county between 2000 and 2004. Column 5B provides updated estimates of the number of women who would seek treatment but are currently not receiving services. The updates utilize the female treatment seeking rates for each Service Area from the STNAP-II study applied to the updated female treatment need estimates for each Service Area aggregated to the planning regions. The updated total number of women who would seek treatment is 25,943. In FY 2005, ADA provided substance abuse treatment services to 15,483 Missouri women whose county of residence (and therefore ADA planning region) are known. By subtracting the women who accessed treatment services from the 15,483 who would seek treatment, an estimated 10,460 women have an unmet demand for treatment. This unmet demand is reported by planning region in column 5B.

Limitation of Data in Columns 3, 4, and 5

The STNAP-II study was conducted from 2000 to 2003. The household telephone interviews, which provided much of the core data for the prevalence estimates, were administered in 2001 and 2002, so much of the data is four or five years old. Although the aggregate treatment need of 491,224 identified by the STNAP-II is very close to the estimate of 499,000 with alcohol or illicit drug dependence or abuse derived from the 2003-2004 NSDUH, components of the NSDUH estimates are very different. STNAP-II estimated that 39,000 adolescents needed substance abuse treatment or intervention, including 29,378 who needed treatment. OAS estimated that 51,000 adolescents have alcohol or illicit drug dependence or abuse. There were also variances in the other age groups between the STNAP-II treatment need estimates and the dependence and abuse estimates from the NSDUH.

ADA will be reviewing the latest NSDUH estimates that are being released in August 2006 for Missouri and its planning regions and will be integrating these survey results into the Missouri prevalence estimates. The sub-state data should provide more clarification on the geographic distribution of Missouri's population in need of substance abuse treatment services.

Column 6: Prevalence of substance-related criminal activity

DWI arrests, drug arrests, and boating while intoxicated (BWI) arrests are included in the Uniform Crime Reporting system. Data is coded according to the county of arrest and aggregated to the ADA planning regions. BWI was selected for reporting in the optional column because Missouri has a large number of lakes and navigable streams that are used for boating, skiing, canoeing, and other water recreation. Alcohol related boat crashes, drowning, and injuries are a significant problem in the state.

Column 7: Incidence of communicable diseases

The data on hepatitis B, AIDS, and tuberculosis are provided by the Missouri Department of Health. The data are aggregated to the ADA planning regions using the county of residence of infected individuals. The rates are based on the number of cases per 100,000 residents in accordance with 2004 population estimates.

State:
Missouri

Reporting Period:
From 7/1/2004 To 6/30/2005

FORM T1 - TREATMENT PERFORMANCE MEASURE
EMPLOYMENT STATUS (From Admission to Discharge)

Employment Status - Clients employed (full-time or part-time) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients employed (full-time and part-time) [numerator]	9,650	10,495	
Total number of clients with non-missing values on employment status [denominator]	28,974	28,974	
Percent of clients employed (full-time and part-time)	33.31%	36.22%	2.92% / 8.76%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T1.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify

T1.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T1.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T1.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T1.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Employment Status Data Collection (Form T1)

GOAL

To improve the employment status of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being employed (including part-time) at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on employment that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

DATA SOURCE(S)	Source(s):	(CTRAC) Client Tracking Registration Admission and Committment. It includes clinical and demographic characteristics of DMH clients. Each provider is responsible for providing information on clients.

DATA ISSUES Issues: N/A

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Missouri

Reporting Period:
From 7/1/2004 To 6/30/2005

FORM T2 - TREATMENT PERFORMANCE MEASURE
HOMELESSNESS: Living Status (From Admission to Discharge)

Homelessness - Clients homeless (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients homeless [numerator]	0	0	
Total number of clients with non-missing values on living arrangements [denominator]	0	0	
Percent of clients homeless			0.00% / 0.00%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T2.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T2.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☒ Other: Specify unable to collect data

T2.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T2.4
Was the admission and discharge data linked? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T2.5
Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☒ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Homelessness (Living Status) Data Collection (Form T2)*

GOAL

To improve the living conditions of persons treated in the States substance abuse treatment system.

MEASURE

The change in all clients receiving treatment who reported being homeless at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☐ NO ☒

State collects admission and discharge data on living status that can be reported using TEDS definitions.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA SOURCE(S) Source(s): N/A

DATA ISSUES Issues: N/A

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost. Living status is not colledted at discharge. It is expected this data will be collected beginning 10-1-06.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Missouri

Reporting Period:
From 7/1/2004 To 6/30/2005

FORM T3 - TREATMENT PERFORMANCE MEASURE
CRIMINAL JUSTICE INVOLVEMENT (From Admission to Discharge)

Arrests - Clients arrested (any charge) (in prior 30 days) at admission vs. discharge - T3	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of Clients arrested [numerator]	22,843	963	
Total number of clients with non-missing values on arrests [denominator]	31,858	31,858	
Percent of clients arrested	71.70%	3.02%	-68.68% / -95.78%

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T3.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify

T3.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T3.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T3.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T3.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Number of Arrests Data Collection (Form T3)

GOAL

To reduce the criminal justice involvement of persons treated in the States substance abuse treatment system.

MEASURE

The change in persons arrested in the last 30 days at discharge for all clients receiving treatment.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on criminal justice involvement that can be reported as a Yes/No response.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

DATA SOURCE(S)	Source(s):	(CTRAC) Client Tracking Registartion Admission and Committment. It includes clinical and demographic characteristics of DMH clients. Each provider is responsible for providing information on clients.

DATA ISSUES

Issues: The state currenty collects arrests during the past 2 years. It is anticipated that beginning 10-1-06 we will begin collecting criminal justice involvement in the past 30 days.

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Missouri

Reporting Period:
From 7/1/2004 To 6/30/2005

FORM T4 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - ALCOHOL USE (From Admission to Discharge)

Alcohol Abstinence - Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from alcohol [numerator]	12,558	17,610	
Total number of clients with non-missing values on 'used any alcohol' variable [denominator]	29,163	29,163	
Percent of clients abstinent from alcohol	43.06%	60.38%	17.32% / 40.23%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T4.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify
- ☐ Urinalysis, blood test or other biological assay
- ☐ Collateral source
- ☐ Other: Specify

T4.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T4.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T4.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T4.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State Description of Alcohol Use Data Collection (Form T4)

GOAL

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change of all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on alcohol use that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

DATA SOURCE(S)	Source(s):	(CTRAC) Client Tracking Registration Admission and Committment. It includes clinical and demographic charateristics of DMH clients. Each provider is responsible for providing information on clients.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA ISSUES Issues: N/A

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

State:
Missouri

Reporting Period:
From 7/1/2004 To 6/30/2005

FORM T5 - PERFORMANCE MEASURE
CHANGE IN ABSTINENCE - OTHER DRUG USE (From Admission to Discharge)

Drug Abstinence - Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients abstinent from illegal drugs [numerator]	15,594	19,580	
Total number of clients with non-missing values on 'used any drug' variable [denominator]	29,352	29,352	
Percent of clients abstinent from drugs	53.13%	66.71%	13.58% / 25.56%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T5.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report confirmed by another source.--> If checked, select one confirmation source.
- ☐ Client Self Report
- ☒ Administrative Data Source
- ☐ Other: Specify
- ☐ Urinalysis, blood test or other biological assay
- ☐ Collateral source
- ☐ Other: Specify

T5.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND Discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☒ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☐ Other: Specify

T5.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☒ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T5.4
Was the admission and discharge data linked? (Select all that apply)

- ☒ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☒ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

T5.5
Why are you Unable to Report?
(Select all that apply)

- ☒ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☐ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

State Description of Other Drug Use Data Collection (Form T5)

GOAL

To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported abstinence at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission data.

YES ☒ NO ☐

State collects discharge data.

YES ☒ NO ☐

State collects admission and discharge data on other drug use that can be reported using TEDS definitions.

YES ☒ NO ☐

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☒ NO ☐

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA SOURCE(S)	Source(s):	(CTRAC) Client Tracking, Registration, Admission, and Committment. It includes clinical and demographic charateristics of DMH clients. Each provider is repsonsible for providing information on clients.

DATA ISSUES Issues: N/A

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

State:
Missouri

Reporting Period:
From 7/1/2004 To 6/30/2005

FORM T6 - PERFORMANCE MEASURE
CHANGE IN SOCIAL SUPPORT OF RECOVERY (From Admission to Discharge)

Social Support of Recovery - Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	Admission Clients (T1)	Discharge Clients (T2)	Absolute/Relative Change
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	0	0	
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	0	0	
Percent of clients participating in social support activities			0.00% / 0.00%

OMB No. 0930-0080 Approved: 8/26/2004 Expires: 08/31/2007

THE SECTION BELOW SHOULD BE COMPLETED AT THE TIME DATA IS ENTERED IN THE TABLE ABOVE

T6.1
What is the source of data for this table? (Select all that apply)

- ☐ Client Self Report
- ☐ Administrative Data Source
- ☐ Other: Specify

T6.2
How is Admission/Discharge Basis defined? (Select one)

- ☐ Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ☐ Admission is on the first date of service in a Program/Service Delivery Unit AND Discharge is on the last date of service in a Program/Service Delivery Unit
- ☒ Other: Specify data not available

T6.3
How was the discharge data collected? (Select all that apply)

- ☐ Not Applicable, data reported on form is collected at time period other than discharge --> Specify:
  - ☐ In-Treatment data days post admission OR ☐ Follow-up data months Post ☐ admission OR ☐ discharge
  - ☐ Other: Specify
- ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment
- ☐ Discharge data is collected for a sample of all clients who were admitted to treatment
- ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment
- ☐ Discharge records are NOT completed for some clients who were admitted to treatment
  Specify proportion of admitted clients with a discharge record: %

T6.4
Was the admission and discharge data linked? (Select all that apply)

- ☐ Yes, all clients at admission were linked with discharge data using a Unique Client ID (UCID).
  Select type of UCID:
  - ☐ Master Client Index or Master Patient Index, centrally assigned
  - ☐ Social Security Number
  - ☐ Unique client ID based on fixed client characteristics (such as DOB, gender, partial SSN, etc.)
  - ☐ Some other Statewide unique ID
  - ☐ Provider-entity-specific unique ID
- ☐ No, State Management Information System does not utilize a UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohort basis) or State relied on other data sources for post admission data
- ☐ No, admission and discharge records were matched using probabilistic record matching

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T6.5
Why are you Unable to Report?
(Select all that apply)

- ☐ Not Applicable, data reported above
- ☐ Information is not collected at Admission
- ☐ Information is not collected at Discharge
- ☒ Information not collected by categories requested
- ☐ State collects information on the indicator area but utilizes a different measure
- ☐ Other: Specify

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State Description of Social Support of Recovery Data Collection (Form T6)

GOAL

To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE

The change in all clients receiving treatment who reported participation in one or more social and or recovery support activity at discharge.

STATE CONFORMANCE TO INTERIM STANDARD

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

State collects admission and discharge data on social support of recovery that can be reported using definitions provided as follows:

Participation in social support of recovery activities are defined as attending self-help, attending religious/faith affiliated recovery or self help groups, attending meetings of organizations other than the organizations described above or interactions with family members and/or friends supportive of recovery.

YES ☐ NO ☒

State reported data using data other than admission and discharge data.

YES ☐ NO ☒

State reported data using administrative data.

YES ☐ NO ☒

DATA SOURCE(S) Source(s): N/A

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DATA ISSUES Issues: N/A

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DATA PLANS IF DATA IS NOT AVAILABLE	State should provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost. Social support participation is expected to be collected begining 10-1-06.

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State:
Missouri

FORM T7: RETENTION

Length of Stay (in Days) of Clients Completing Treatment

Length of Stay			
LEVEL OF CARE	**AVERAGE**	**MEDIAN**	**STANDARD DEVIATION**
DETOXIFICATION (24 HOUR CARE)			
1. Hospital Inpatient	**0**	**0**	**0**
2. Free-standing Residential	**0**	**0**	**0**
REHABILITATION / RESIDENTIAL			
3. Hospital Inpatient	**0**	**0**	**0**
4. Short-term (up to 30 days)	**0**	**0**	**0**
5. Long-term (over 30 days)	**0**	**0**	**0**
AMBULATORY (OUTPATIENT)			
6. Outpatient	**0**	**0**	**0**
7. Intensive Outpatient	**0**	**0**	**0**
8. Detoxification	**0**	**0**	**0**
9. Methadone	**0**	**0**	**0**

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Form T7 Footnotes
It is anticipated that the state will have the infrastructure in place beginning 10-1-06 to capture this data at admission and discharge.

Form P1

State:
Missouri

Reporting Period:
From 7/1/2004 To 6/30/2005

Prevention Form P1
NUMBER OF PERSONS SERVED

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Persons served in Block Grant funded services include all persons served in prevention programs that receive all or part of their funding through the SAPT Block Grant.

AGE	TOTAL	SINGLE SERVICES	RECURRING SERVICES	RACE/ETHNICITY	TOTAL	SINGLE SERVICES	RECURRING SERVICES	GENDER	TOTAL	SINGLE SERVICES	RECURRING SERVICES
0-4	631	611	20	American Indian / Alaska Native	77	73	4	MALE	63779	39943	23836
5-11	36084	6904	29180	Asian	877	820	57	FEMALE	54456	31832	22624
12-14	28993	17346	11647	Black / African American	5021	12793	37408				
15-17	13080	9607	3473	Native Hawaiian / Other Pacific Islander	287	287	0				
18-20	2505	1787	718	White	62088	53832	8256				
21-25	3063	2810	253	More than one Race	1677	1447	230				
26-44	20496	19613	883	Unknown	3028	2523	505				
45-64	12187	11912	275	Total	73055	71775	46460				
65+	1196	1185	11	Not Hispanic Or Latino	116018	70002	46016				
				Hispanic Or Latino	2217	1773	444				
Total	118235	71775	46460	Total	118235	71775	46460	Total	118235	71775	46460

State:	Reporting Period:
Missouri	From 7/1/2004 To 6/30/2005

PREVENTION FORM P2
NUMBER OF EVIDENCE-BASED PROGRAMS, PRACTICES, AND POLICIES

Programs include all prevention programs, practices, policies, and strategies that receive all or part of their funding through the SAPT Block Grant.

1.List NREPP programs or practices below.

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

2.List programs or practices from lists recommended by other Federal agencies.

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

3.List peer-reviewed journal-evidenced programs, practices, and policies (attach journal citation).

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

4.List the names of other evidence-based programs, practices, and policies (attach source and type of evidence).

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total

5.List the names and sources of other non-evidence-based programs, practices, and policies (attach additional information on the program, practice, or policy).

Program Name and Source	Universal Populations	Selective Populations	Indicated Populations	Total
Universal Programs	92704	0	0	92704
Selective Programs	0	16482	0	16482
Indicated Programs	0	0	4787	4787
Subtotal	92704	16482	4787	113973

TOTALS

GRAND TOTAL all programs, practices and policies	**113973**
Percent Evidence-Based (sections 1 - 4 above)	**0%**
Percent Non-Evidence-Based (section 5 above)	**100%**

Form P3

State:
Missouri

Reporting Period:
From To

PREVENTION FORM P3
PERCEPTION OF RISK/HARM OF, AND UNFAVORABLE ATTITUDES TOWARD SUBSTANCE USE BY THOSE UNDER AGE 21

For perception of risk/harm, report the number and percent of the State population who responded “slight risk”, “moderate risk” or “great risk” (add the three categories).

For unfavorable attitudes, report the number and percent of the State population who responded “somewhat disapprove” or “strongly disapprove” (add the two categories).

Indicator	Drug	No. of Respondents	Percent of Respondents
Perception of Risk/Harm of Substance Use	**Alcohol**	**0**	**0**
	Cigarettes	**0**	**0**
	Marijuana	**0**	**0**
Unfavorable Attitudes Toward Substance Use	**Alcohol**	**0**	**0**
	Cigarettes	**0**	**0**
	Marijuana	**0**	**0**

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Form P4

State:
Missouri

Reporting Period:
From 7/1/2004 To 6/30/2005

PREVENTION FORM P4
USE OF SUBSTANCES DURING THE PAST 30 DAYS

Report the number and percent of the State population who responded having used at least one or more times in the past 30 days.

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Drug		12-17 year olds	18-25 year olds	>26 year olds	Total
Alcohol	**N**	**0**	**0**	**0**	**0**
	%	**0**	**0**	**0**	**0**
Tobacco	**N**	**0**	**0**	**0**	**0**
	%	**0**	**0**	**0**	**0**
Marijuana	**N**	**0**	**0**	**0**	**0**
	%	**0**	**0**	**0**	**0**
Cocaine/Crack	**N**	**0**	**0**	**0**	**0**
	%	**0**	**0**	**0**	**0**
Stimulants	**N**	**0**	**0**	**0**	**0**
	%	**0**	**0**	**0**	**0**
Inhalants	**N**	**0**	**0**	**0**	**0**
	%	**0**	**0**	**0**	**0**
Heroin	**N**	**0**	**0**	**0**	**0**
	%	**0**	**0**	**0**	**0**

Missouri

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

State applicants should include a discussion of topics relevant to outcome reporting in general. This would include topics mentioned in instructions above as well as any additional information (e.g., data infrastructure needs) that the State deems important.

Effective 10-1-06 Missouri will go live with the new Customer Information Management, Outcomes, and Reporting (CIMOR) system. The CIMOR system is designed to include the reporting requirements for clients receiving treatment services as outlined in the SAPT Block Grant as well as TEDS and SOMMs reporting.

Missouri

Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)

No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.